Out of the institution?: exploring the culture of community psychiatric nurses.

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Abstract.

The literature shows that there is a lack of knowledge about the practice of the relatively new profession of community psychiatric nurse who initially train in hospitals and then move to the community. The research undertaken for this thesis is designed to address this lack of knowledge by exploring the views of community psychiatric nurses practicing in South Durham.

Using a Weberian perspective, it was proposed that the collective cultural beliefs of the CPNs would reflect perceived differences between hospital and community psychiatric nursing. The culture was explored through 30 semi-structured interviews with the CPNs working for South Durham Mental Health Trust in 1996/7.

A series of cultural beliefs (categorised as "themes") were found which described views about the differences between psychiatric nursing in hospital and the community, in the disorders found in each patient group, relationships with consultants psychiatrists and general practitioners, relationships with other health and social care professionals and what constituted a "good" community psychiatric nurse. There was also a theme which related to all the others, which concerned threats to their professional identity, as seen by the CPNs, in terms of their status as a distinct group of health care workers.

The findings show that the CPNs provide care for a wider range of disorders than found in hospital patients. There is no mandatory training which leads to a variety of strategies by which they learn to treat unfamiliar disorders. Relationships with medical staff, and other professionals, have to be re-negotiated when moving from hospital to community. It also appeared that the CPNs perceived a threat to their professional identity as a consequence of the changes in mental health care which were occurring at the time of field work, involving both the NHS and social care agencies.

Out of the Institution?
Exploring the Culture of Community Psychiatric Nurses.

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Preface.

"There are nine and sixty ways,
of constructing tribal lays,
and all of them are right"
(Rudyard Kipling)

List of Abbreviations Used in the Text.

BNT	Behavioural nurse therapist
CHC	Community Health Council
CMHT	Community mental health team
CPN	Community psychiatric nurse
DETR	Department of the Environment, Training and the Regions
DoH	Department of Health
ECT	Electro convulsive therapy
ENB	English Nursing Board
GNC	General Nursing Council
GP	General practitioner
GPFH	General practitioner fund holder
LA	Local Authority
MH	Mental health
MHA	Mental Health Act 1983
MHP	Mental health problems
MI	Mental illness
NHS	National Health Service
PAM	Profession(s) allied to medicine
PCG	Primary care group
PCT	Primary care trust
RGN	Registered General Nurse
RMN	Registered Mental Nurse
RMO	Responsible medical officer
SWD	South West Durham Health District
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Introduction

In the past the convention for beginning a story was "once upon a time..." and that phrase is still a fitting start for the present account. In 1987 my first employment with the National Health Service (NHS) was a research project which included a survey of the work of a mental health unit in what was then South West Durham District Health Authority- roughly the Local Authority areas of Sedgefield and Wear Valley Districts in County Durham. The unit was based at, and dominated by, Winterton Hospital, near Sedgefield, which was a large mental hospital founded in 1858 and housing, in 1987, nearly eleven hundred patients who originally came from all over the Northeast of England, with a few from farther afield.

As part of the Government's policy of finding alternatives to long-term institutional care a community psychiatric nursing (CPN) service was created in 1976. This engaged a small team of eleven people, with a manager, based in Spennymoor in 1987 with outreach sessions at doctors' surgeries throughout the South Durham area. At that time there was little information routinely collected in the NHS beyond an annual count of the number of referrals received by the team and the number of contacts they had made with their patients, now to be called "clients". This data collection itself was a recent innovation, introduced following the deliberations of the Körner Committee on the need for management information in the NHS (Körner Report, 1982). However, the "Körner" data, as it came to be known, did not provide any information about the nature of the work the CPNs were undertaking, the setting in the community or the problems for which the clients were being referred. The CPNs worked with a degree of isolation from the hospital and unit managers. This led the General Manager of the time, who was a qualified psychiatric nurse and also Director of Nursing, to seek further information about the activities of the CPNs. His instructions were "go out there and find out what the hell they are doing, will you".

At that time the NHS favoured quantitative research therefore much of the 1987 survey was concerned with demographic and epidemiological analyses of the

CPN caseload. To supplement these data a short qualitative questionnaire was also used which enabled the CPNs to identify issues of importance to them. The results showed that there were strong feelings of isolation from the hospital which were felt to dominate everyone's perception of provision and services for mental health care, a lack of understanding of the CPNs' work by ward staff and senior nursing staff in the unit and a similar lack of understanding of the CPNs' client centred, "holistic" philosophy by hospital based nurses. There was also a strong feeling of not having a clear remit for CPN practice, of being left "to make up their remit as they went along". Several CPNs were aware of Goffman's (1961) work on institutions, which was quoted, and were vociferous in their condemnation of the institutionalisation they thought had happened in the hospital, particularly for people who had been there, both as patients and staff, for many years.

There were three influences on the direction of the research discussed in this thesis. My initial work was the first. Goffman's work, which was known to the CPNs and quoted by them in the context of the undesirability of long term hospital care, on the culture and workings of total institutions was a second influence. The third influence was the gap, perceived by CPNs between their work and that of the hospital ward. These influences, coupled with the quasi-sociological views held by CPNs about institutions raised questions for me about the possibility of a coherent CPN culture existing, and if so, how was the CPNs' training and experience as RMNs in hospital accommodated in the CPN culture.

There were also some relevant ideas from my academic reading, particularly Weber's theory of bureaucracy, which refers to the operation of a large formally defined organisation such as the NHS, which suggested that psychiatric nurses would be trained in, and gain experience in, a hierarchical environment; the hospital ward. When a psychiatric nurse became a CPN they moved to a much more unstructured environment apparently with fewer hierarchical feelings. The difference between the two settings raised the question of how far the hospital based training and experience would influence the CPNs' views about their work in the community. Weber's theory of "culture" was also of interest because it suggests that the views of an individual will reflect the "rules" and social

structure of the world in which a person acts and lives. The underlying values driving the formation of individual views are sometimes explicit and sometimes implicit but can be revealed by deduction, using people's descriptions of their actions. These two theories provided a theoretical perspective for framing my questions as well as providing me with a method of understanding the nature of the CPN culture framed in its own terms.

Another influence on my thinking was that in my working life in Winterton Hospital, where I was based for nearly ten years. I observed that people who had worked there for a long time were highly aware of the existence of a discrete and distinct "hospital" culture. The hospital came into being during the late 19th century, set in 200 hectares of parkland, and had continued to grow during the first half of the 20th century. Until the 1960s it had been behind high walls with locked gates and limited access to and from the outside world. It was designed to be self sufficient in the past as much of the food needed for the patients was grown on a farm attached to the hospital or on market gardens within the walls. For example, great pride was shown in stories about a prize-winning breed of pig owned by the hospital, the Winterton White. Within the grounds, no longer walled and restricted of access, in 1987, were a clothing shop, a general dealers' shop, a post office, a tea room for patients, a leisure centre for patients, a building department, a cobbler's shop, a printer's shop, a patients' library, a staff library, a patients' bank, a staff bank, a school of nursing and a fire station manned exclusively by hospital staff. When commenting on this self-sufficiency, when I joined the unit, the response from a senior nurse with long service was "if Winterton needed to build ships there would be some-one on site who knew how". Many staff lived on site or nearby in hospital houses and some were the third generation of their family to be nurses at the hospital. One showed me an ornate pass key which had belonged to his grandfather and had been handed down the family as each generation found employment at the hospital.

One example of the hospital culture, involving patients who were resident for many years, was demonstrated when a patient with a longstanding psychosis mistook me for one of the senior nurse tutors and in a moment of insight remarked "you know Mr X, between us we've trained a few nurses". This person

had seen many generations of trainee nurses come and go and appeared to have a proprietorial interest in the process of training them. It was a novel point of view but led to a realisation of the symbiotic nature of the nurse-patient relationship in mental health care, whether institutional or not.

As most of the CPNs were drawn from nursing staff who had trained and gained experience in this environment, one of my research questions concerned the nature of the culture that would develop amongst CPNs and, more specifically, what views would they take with them from the hospital to the community? A further issue was, how would any transferred views be modified in the light of the CPNs' antipathy to the hospital, noted in my initial work, and its care for patients?

The opportunity to attempt to answer these questions did not come until 1994 with the opportunity to begin work on a research thesis at Durham University. The Chief Executive and Board approved an application for funding and study leave to do research on the CPN culture because they felt that having more detailed knowledge in this area could contribute to debates on the future direction of service development in mental health and to the training of CPNs. The setting for the work was at the time was South West Durham but shortly after work was begun the Trust merged with South Durham Health Care NHS Trust to form South Durham NHS Trust which added the Local Authority areas of Darlington and Teesdale to the original catchment areas of Wear Valley and Sedgefield. During the period of the work I was employed as a Research and Planning Analyst by the Trust where applied research projects formed part of the normal daily workload.

Three main research questions emerged:

- is there a set of values held in common by CPNs which could be described as forming a culture?
- if so, what are the constituent values of this culture?

- how are hospital acquired views accommodated in the community framework and what effect, if any, do they have on practice in the community?

This thesis is a record of how answers to these questions were sought. The quote from Rudyard Kipling at the beginning summarises the objective nicely: "tribes" have stories which they tell themselves and others about their understanding of the world they live and act in: my aim was to look at the "tribe" of CPNs and elicit their story about themselves.

Chapter 1 discusses the underpinning ideas and definitions of "community", the asylum as an "institution" and "community care" in order to provide a framework for the more detailed discussions which follow.

Chapter 2 is concerned with the development of psychiatric nursing within the broader development of mental health care and with the effects of the Mental Health Act 1983. The issues of definition and scope in psychiatry are also considered. This leads to a discussion of the perceived issues in community psychiatric nursing.

The geographical setting and the structure of mental health services in South Durham at the time of the research are briefly discussed in Chapter 3.

The theoretical approach and thinking which underpin the research are treated in Chapter 4: how Weber's work on bureaucracy and culture was used to frame the research questions and the proposed method of data collection. The limitations of the method are discussed. This chapter also considers the issues of the setting for the research, the sample of CPNs, entry to the field, data collection and analysis, and possible threats to validity.

The analysis of the data is presented in Chapter 5 where the main themes which emerged from the interview material are discussed and a possible link between them, that of threat to professional identity, is proposed.

The final section, chapter 6, considers the usefulness of the theoretical approach and the extent to which the themes that were analysed have contributed an answer to the original questions. This is followed by a discussion of relevance of the findings in the wider context of mental health care in the community and the significance of the findings for the future development of the CPN service. The final paragraphs are a short critique of the work and reflections on the research.

Chapter 1. Mental Health Care in the Community.

Any study of the role and practice of community psychiatric nurses needs to explore the context in which they work. In order to set the scene for the work, this chapter will discuss relevant issues in the provision of mental health care by the NHS. The development of community psychiatric nursing, which will be discussed in the next chapter, has both shaped and been shaped by these developments. The research questions, interview topics and subsequent interpretation of the interview data were thus also shaped by this broad context.

Care for people who have mental health problems has changed greatly since the middle of the 20th century. As will be discussed later, when effective drug therapy became available, caring for people with severe and enduring mental disorders in the community became more acceptable and for the last four decades, or so, has been a policy goal for government. However, the move from "warehousing" people in the large asylums of Victorian times to providing effective care in the community has been a long and difficult process and was still ongoing whilst my research was proceeding.

Before discussing the development of "community care" it is necessary to consider a primary and fundamental issue: possible confusion about what the word "community" means to all those using it in relation to mental health - policy makers, doctors and nurses, clients and their family or carers.

The concept of "community".

The concept of "community" is used with varying degrees of precision and with a variety of meanings and connotations. It is a fundamental idea in current health care policy and is central to the work of the group of people who were the subjects of the research. This section will consider some definitions of "community": it will be argued that there is no single accepted definition in use and that the only meaning all users have in common is a vague one. This suggests that there is a strong possibility that policy makers, CPNs and clients all

have a different idea of what "community" care means to them and therefore also different expectations of what community care is intended to achieve.

The idea of "community" has been used so often in sociology, policy making and the health care field that it has become a "given" which is "understood" more often than it is defined: one dictionary of sociology (Abercrombie *et al*, 1994) begins its entry for "community" with the comment that "*The term...is one of the most vague in sociology and is now largely without specific meaning*"(p 74).

The study of community is often taken to begin, for sociology, with the work of Tönnies, in 1887, (republished 1955) who was looking at the effects of industrialisation and urbanisation. He provided qualified definitions of the rural and urban communities he observed as he studied the way people moved from living in small rural settlements to the larger towns that were growing to support increasing levels of industrialisation in Germany. These "ideal-type" definitions are *Gemeinschaft*, describing the characteristics of a rural community, and *Gesellschaft* which describes the urban community The word Gemeinschaft means "community" in modern German and Gesellschaft means "association" and has become the word for a business.

In this typology, the rural community is small, relatively self sufficient for its needs, although with some interdependence between individuals, and has a strong sense of tradition which is linked with the repetitive cycle of work on the land. Most of the work tasks can be undertaken by individuals or small groups of people. There are strong social ties and kinship groups and everyone is familiar with the other inhabitants of the village. There is also a sense of "belonging" to the community, an identification with, and membership of, the community as something to be valued. Only a small and simple administrative superstructure is needed to ensure that order and functioning are maintained.

In contrast, Tonnies argued that the urban community has few of the characteristics of a rural society; there are changing demands of work in industry, kinship groups are more likely to be fragmented by geographic and occupational mobility, social relationships between people are be based on a wider variety of

tasks and needs to be fulfilled and there is less sense of belonging. Work is likely to require the combined efforts of large numbers of people, each performing only part of the overall task. A large and complex administrative superstructure is needed to deal with the correspondingly complex structure of an urban environment. Things which can be settled between individuals in a small village setting now need many more rules and intermediaries .

Weber (Weber, 1947) also drew on these distinctions and discussed the processes by which the two forms of living, rural and urban, came into being (discussed in Aron, 1980) seeing the two styles of living as the outcome of meeting the social needs of the group. This means that, in a traditional rural society, those concerned have a relatively small number of needs which are bound up with the cyclic processes of farming and that those living under such conditions will tend towards the Gemeinschaft style of living whereas those who seek the extra benefits and opportunities of living in a town will have to create the more complex and differentiated structure which is needed to sustain the production of the associated extra benefits.

Weber makes two points. The first is his argument that the structure of communities is created by their members and is not imposed from the outside in some way - it is the consequence of the collective choice of individuals and created by their actions. The second point is that he sees the two different types of society as dichotomous with industrial societies developing from the more rural closed type as a consequence of a collective choice to have material goods which in turn develops into a dominant means of producing goods and services.

A similar distinction was made by Durkheim, in *The Division of Labour in Society* (Durkheim, 1933, 1964, Aron, 1980, Thompson & Tunstall, 1981,) into the mechanical and organic. The contrast refers to the similarity in the lives and views of members of the rural, mechanical society, where people are relatively interchangeable, and the differentiation in the lives of those whose live in an urban, organic, industrial society. His major contribution is to show that the differentiation in the urban setting does not necessarily destroy the solidarity found in the rural setting but can lead to a new form of solidarity between people

which is not economically determined, as implied by other writers, but which is determined by the free choice of individuals and the laws and rules they devise to regulate relationships between them.

Early work on the idea of community placed an emphasis on the changes which were then occurring as industry grew and spread. There was pessimism, despite Durkheim's argument, that the changes wrought by the spread of industrialisation would destroy the older, tightly knit rural, and apparently desirable, community in favour of a less coherent and looser community structure. Whether or not the larger industrialised community is desirable it is now the most dominant in our society and the small traditional rural community hardly exists. In the late 19th and early 20th century there was still a sizeable proportion of people living on the land and farming methods were still largely traditional, but today, a smaller number of people work in the rural environment and farming is a highly mechanised and automated industry (Williams, 1963, OPCS 1991 Census). And further, even where rural "remnant" villages do exist they often have "incomer" residents who work in larger nearby towns. Other factors have also changed, particularly the speed and ease of communication; today television and newspapers transcend the social and geographical boundaries which existed in the past. The village has not remained as a static counterpoint to rapidly changing urban society, it has changed in parallel.

Subsequent research on "community" placed more emphasis on the urban setting with a change of scale from consideration of the major divisions occurring on a national level to consideration of the detailed structure and functioning of the urban setting itself, possibly because the bulk of the population now lived in towns. In 1801 only 17% of the British population lived in towns, in 1851 it was about 50%, with 23% living in rural communities, and is now about 80% with ~ 2% in rural communities, the lowest in the world (ONS website) although the growth of the dormitory village, and the placing of industry away from towns, mean comparisons have to be made with caution.

The identification of rural with community and, by implication, the town as non-community, has changed as has the definition of "community": for some writers

the concept has come to mean any group of people who "*...share...a whole set of interests wide enough and complex enough to include their lives.*" (defined by McIver & Page 1931, and still used in Calvert & Calvert, 1992). Enlarging the definition of community, based on geographical proximity, with the idea of people sharing social settings which are not geographically based widens the possible interpretation and meanings of "community".

Whatever the meaning people attach to it, in everyday use the term "community" seems to have vague positive associations with supportiveness and solidarity which echo the characteristics of a "Gemeinschaft" society. The main issue is that as "communities" become larger they also develop complex material infrastructures, which in turn means the population of the community become specialists in specific aspects of maintaining the infrastructure. In a small settled community most people can know each other, but in modern large-scale societies, with high population mobility, this is not possible. There is a tendency to find groups of people with common experiences and goals forming something like a "community" and an individual may be a member of several such groups such as family, work and leisure interest groups.

The possibility of a "community" having negative and perverse characteristics and effects on its members is not always apparent although my previous work (1987) with the CPNs suggested that they were aware of the possibility of clients being isolated in the community as it exists today – of being in the community but not part of it. They did not use the term "under class" specifically but described the possibility in very similar terms which was defined by their observations of stigma about mental health in the community. The complexity of the concept of an underclass has been debated by political scientists as well as sociologists (Willis, 1977, Wilson, Peterson, 1991) but for many commentators the main determinants for an underclass consist of people living in an area with high levels of unemployment, a marginal position in the local economy, a weak attachment to the labour force, social isolation as a group, and a neighbourhood with a social milieu which reinforces and perpetuates these characteristics (discussed by Dahrendorf in Smith, 1992). If this is the case, people with mental

disorder living in many areas in the South Durham catchment could fall into this category and the CPNs' previous observations may be accurate.

If people with mental disorders form an under-class in the community there are potentially negative consequences for their well-being. First to be a member of an underclass may be to be more vulnerable to mental disorder than one would be under other circumstances. Secondly and almost paradoxically the converse may occur - to become mentally disordered may lead to becoming part of an underclass defined by the condition itself followed by the effects of stigma which operates to depress the chances of employment, and to create long term dependence on benefits, which in the long term can block a person from many things such as an adequate income, good housing, social contacts, marriage, material goods and holidays. There is some evidence to support the possibility of the existence of a underclass caused by mental disorder; psychotic ex-patients tend to undertake "inner city drift" where they seek the anonymity of bed-sitter-land in large cities. (Wing, 1971). Because this group of people are seeking to minimise their social contact with others it is not apparent how living in the "community" has any benefits at all except that it may mean that they can minimise social contact by "hiding" away from other people.

Others, suffering from non-psychotic problems or having a controlled psychotic condition, may also be part of an underclass in which there is a sense of shared community based on attendance at day centres, with short spells in hospital, where the patients are known and have formed a social network, whilst remaining relatively out of touch with the wider community. (Ricketts & Kirschbaum 1994.)

The significance of the existence of varying definitions and expectations of "community" raises several significant issues for patients and staff who are involved in the closure of large mental hospitals and the creation, and future direction, of services based outside any hospital setting. These themes are of significance for policy makers who have to produce workable strategies for change on a national basis and yet have to allow for the rich variety of situations which exist when society is examined on a smaller scale.

One issue is that a large mental institution could be considered as a community in its own right and may also be part of the local community immediately outside its walls. Long term residents who have spent many years in such a setting may have a sense of community, and a social network, based on their life in hospital, which can be destroyed by moving them to other places. A corollary to this is that a community may not be apparent to anyone but those who live in it and even if it is a recognisable entity to outsiders its needs may not be apparent, or even articulated, until they are disturbed.

A second issue is that many of the proposed changes to the care of mentally disordered people have moved from the known, and tested, to the untried. (Lilley, 1995). The dangers of large scale Utopian versus piecemeal social engineering are discussed by the philosopher Karl Popper in an early paper (Popper, 1944) which argues for small-scale change, with evaluation, instead of large-scale policy driven change which is difficult to evaluate and to reverse if the evaluation is negative. The 1990 Community Care Act, to be discussed in detail in a later chapter, required change on a large scale although it could be argued that the generality of the proposals and the lack of specific definitions of "community", "community care" and " care in the community" allowed for local variation and circumstances which in practice can be taken into account by government agencies when assessing need and purchasing services. This should lead to a cycle of development, evaluation and adjustment which would provide knowledge of the most effective ways of delivering community based services. However, without this approach, there is a danger that inappropriate services may be imposed on patients even when the ethos is that services are to be "patient centred" rather than "profession driven". Evidence (van Os and Neeleman, 1994), suggests that clients of community based services have different goals and expectations of different services when compared with professionals even when services are intended to be "patient centred" and thought to be sensitive to patient, or client, needs.

Another issue is concerned with what features of "community" are thought to make it a suitable place to situate services and into which to place those who

have, or have had, mental health problems. There are two sub-issues; placing ex-long stay patients into a community where they have not previously lived, or have not lived there for many years, and, secondly, taking services to people who continue to live in their community. In this latter case it is the services and those who provide them who are new to the community. Groups of ex-patients placed into a community which is hostile to them may experience isolation similar, or more marked, than that found in the large "asylum" (Prior, 1993). There is also the issue of stigma, which may exists in all types and sizes of communities, which may prevent those with any association with mental disorder from becoming accepted as full members of the community.

For example, observation of three schemes in County Durham to introduce ex-long term patients (from both mental health and learning difficulties facilities) into independent living in a community, showed in all cases some acceptance by those living in the local community. However, there was also a great deal of persecution by local adolescents involving verbal abuse, vandalism of property, attempts to "con" money from ex-patients and often a general abuse of their rights, presumably because they were perceived as unable to defend themselves (Management Report, South West Durham Mental Health Unit, 1994). In the case of two ex-psychotic patients with some still active symptoms (hallucinations and scavenging) there was some concern expressed by neighbours about the safety of their small children. Two things became obvious; that there was a lack of knowledge and awareness in the public at large about the nature of mental disorder and learning difficulties and, secondly, that the ex-patients were not accepted as full members of the community in which they lived.

One thing is immediately apparent from the discussion shown above: the term "community" is not a simple synonym for "society at large" although it is often used loosely in this sense by NHS staff who work outside the hospital. Amongst those working in mental health services there also appears to be an implicit, but poorly defined and articulated, idea that living in the community is always preferable to be in hospital except for times when people are likely to harm themselves or others. (Noted whilst working with clinical staff on service developments.) The expressions working “on the community”, or “out in the

community" are frequently heard from staff meaning largely "working with people in their own homes" and not necessarily with the sociological connotations discussed above.

Having considered "community" it is appropriate to consider the situation of people living away from the wider community, the idea of "institutionalisation", before looking at the policy and legislation leading to community care existing at the time of the research.

The asylum as an "institution".

The ideas of "institutionalisation" and "total institutions", deriving from Goffman's work (1986), were significant in developing my research question. The work showed that there were many organisations, which he called "total institutions", where people live cut off from wider society and whose lives are dominated by a set of rules designed to achieve the institution's objectives. He identified such examples as the armed forces, prisons and some types of hospitals (mental health and isolation hospitals for contagious diseases) as particular examples. A total institution he defined as *"a place ... where a large number of like minded individuals, cut off from wider society for an appreciable period of time, together lead an enclosed formally administered round of life... "* (p. xiii) The link between them is that *"... what is prison-like about prisons is also found in institutions whose members have broken no laws."* (p. xiii)

Goffman carried out fieldwork in an American mental hospital which showed that the rules and requirements of the organisation came to dominate the lives of the patients and led to a culture which sought to accommodate the needs of the patients with the rules of the organisation. Much of the reported behaviour of patients was designed to evade or avoid the "rules", to avoid incurring censure or punishment, but was nevertheless almost entirely a response to the rules themselves. Patients in the mental hospital were "dehumanised" by those running the hospital, in order to be made well, by being made to give up their clothes and personal ideas from the outside world in favour of clothing and ideas approved by the institution. This process was seen as helping to impress the rules and

requirements of the organisation firmly in the minds of the patients who apparently also "taught" the working of their culture to newcomers. The sanction used by the institution was that being judged well enough to leave involved accepting the rules and demonstrating that acceptance to the satisfaction of the doctors.

It was found that staff were also to some extent institutionalised, albeit in a somewhat different way to the patients because the staff at least could escape the institution and return to contact with the wider world at the end of their work period. However, as the staff themselves were the agency by which the rules of the organisation were implemented there is the likelihood they had accepted the rules as legitimate and were also subject to other rules governing how the requirements for patient behaviour were to be enforced and also how their authority was to be exercised.

The issues outlined above were very apparent to me when joining the NHS in 1987 as I went to work at Winterton Hospital, which had been founded in 1858. It was big, old and on an isolated site with a clearly articulated tradition of "how things are done here" which I was taught in addition to the actual requirements of the job. (Which was to research the information needed to develop alternative services as the hospital retracted and re-housed long term patients elsewhere. The work was reported to the South West Durham District Health Authority as *"Services and Information Needs in South West Durham"* in 1988). The first task was a qualitative and quantitative survey of the work of both community and hospital staff.

Early work with the CPNs, in 1987, showed that "institutionalisation" was an important issue for them and they held explicit views about mental hospitals versus care in the community. A further project, which assessed the daily functioning of long stay patients in Winterton Hospital (Marshall & Bilbé, 1992), also found that hospital based nurses were aware both of the concept of institutionalisation and of the work from which it came (Barton, 1959, Goffman, 1961). In nearly all cases institutionalisation was seen as bad and to be avoided

as far as possible although with some reservations if patients were seen as too damaged to be able to care for themselves in the wider community.

The CPNs, when interviewed and surveyed in 1987, were highly critical about the way mental hospitals had treated patients in the past. Hospital-based nurses also had strong feelings about what the "system" had done to long stay patients, some of whom had spent more than four decades in hospital. In spite of the potential loss of employment for themselves as nurses, some were keen to see the closure of long stay facilities in old mental hospitals in favour of community based facilities for the care of patients. There were differences about the alternatives: CPNs favoured care by the community, independent living or with family/carers, with some inpatient care as an alternative but hospital nurses generally wanted smaller, more modern, mini-hospitals sited in the community. The concept of the total institution was found to be almost synonymous with the old mental hospitals which were reaching the final phases of retraction in favour of other types of care at the time of the in-house research done at Winterton Hospital (Survey of patient residence preferences, 1992).

Although both hospital and community mental health nurses used the idea of a total institution it was not clear whether they were using it naively, without any real knowledge of the literature, and whether they were aware of differences in the American and English mental health care systems which may be significant when applying the idea locally. Very few of the nurses appeared to be aware of the major criticisms of Goffman's work, such as the assumptions which appear to underpin it but which are not made explicit. For instance, Scull (in Bean, 1985) offers a hypothesis that the negative aspects of the work were readily accepted because they legitimised the ideology that community treatment was always preferable to hospital care when there is little evidence to support that assertion. Scull suggests that, in Goffman's work, there is no examination of the reasons why the patients were in hospital, beyond an impression that the patients were arbitrarily detained against their will. There is also no comparison of the hospital setting with any possible alternatives to hospitalisation.

The nurses appeared to focus on such characteristics of a total institution as the dehumanising processes by which an "inmate" is stripped of her/his individuality and will until they become subservient to, and acquiescent in, the regime of the institution. It is questionable whether the extent and thoroughness of this process in a British mental hospital in the 1980/90s is comparable to the situation found by Goffman in American mental hospitals in the 1950/60s but nurses appeared to feel that the fact of forcible detention, in some cases, and the recognition of the existence of institutionalisation (Barton, 1959) imply that there is a regime which controls and orders the lives of patients in a similar way to that described by Goffman.

It was also recognised, by the CPNs, that when relocating long term patients to the community outside the hospital one can be disrupting a patient's long term friendships, social networks with other patients and staff and, in some cases, social networks with the locality immediately around the hospital: shopkeepers and publicans for instance. In most cases the relocation, and move to a new situation, has been done with a great deal of care (Tomlinson, 1991). The literature on the outcome of relocation is patchy, but there have been some cases where there appears to have been real problems even to the extent of ex-patients going to jail for lack of other accommodation. (Press reports during 1993-1996 included one about a judge who threatened to have the Health Secretary appear before him if hospital accommodation was not found for a particular prisoner.) Homelessness and unemployment are reported problems for some ex-patients who are thereby denied the option of trying to integrate into the community outside the hospital. (Morgan 1993)

The discussion of the concepts of "community" and "institutionalisation" now leads to the issues of making a transition from the institution to the wider community for patients as the big old hospitals closed.

The issues in "community care".

The idea of community care has been used for more than four decades (Titmuss 1968) in policy documents and the debate is not a new one in spite of the

prominence it has achieved in the NHS, the political arena and the press since the 1990 Community Care Act, followed by the National Plan (2000) and the creation of Primary Care Trusts (2001).

Like the term "community" the idea of "community care" is perhaps more assumed to be understood than clearly defined. In the simplest definition it is seen as "...*extra mural care (community care)*...." (van Os & Neelman, 1994) i.e. "not in a hospital". This definition appears to be the most commonly used sense of the word and, whilst it is relatively clear and uncontroversial on the surface, it can be misleading in use as it encompasses everything from small medical hospital-type units set in a town to the most radical approach of involving people in their care in an interactive way. There appears to have been little consideration by policy makers of the debate in sociology about the nature and function of a "community" in general and about the value of a "community" in mental health (Prior, 1993).

A set of papers edited by Wing also has the implicit meaning of "not in a big hospital" (Wing, 1982) and is specifically concerned with the rehabilitation of long term patients and their transfer from the big old hospital to smaller facilities scattered through the surrounding area. The use of the term community in this context is a geographic one as the facilities proposed are intended to provide much the same kind of care as would be found in hospital: residential care, more independent hostel living and day care. This is fairly typical of much of the literature where "community care" is often used as a synonym for "care in the community", referring to location of services. rather than to a different kind of service. At the other extreme the same term is used to describe a kind of service designed to foster a healthy community - in this case the community itself is the patient. (Heller, 1978)

Against a background of multiple change for the NHS and Local Authorities in the late 1980s and 1990s, undertaken over a relatively short span, I feel it can be argued that time pressures have precluded a thorough and extensive consideration, by Government and the NHS, of the intricacies of defining "community care". However, this is a difficult point to sustain given that such

changes were first mooted after the 1959 Report of the Royal Commission (HMSO, 1959); in 1961 Enoch Powell first announced the planned run-down of psychiatric hospitals (Powell, 1961) and there have been several other initiatives since then to add to the momentum for achieving change. Given that it is central to the work of the CPNs, it is worth spending a little time on the main policy initiatives aimed at promoting care in the community in order to demonstrate that even after nearly forty years of effort there is still much confusion and a lack of clarity about how care in the community should function.

The Percy Report (HMSO, 1959) on the law regarding mental illness and mental deficiency *(sic)* was one of the most influential factors in the early moves to care in the community and was the first major reassessment of policy for care of those with mental disorder since the laws of 1890 and 1913. It is of interest because many of the issues raised in the Report are still part of the debate today in spite of subsequent legislation. The Commission was sitting at a time when new medication, psychotropic drugs, was making the treatment of many distressing conditions more effective and therefore making it a real possibility that patients could live outside a mental hospital. In spite of this, the wording of the Report and some of the conclusions it draws from its hearings are very questionable from our standpoint 40 years on.

The authors of the Report make the bald statement at the beginning of their work that "*Disorders of the mind are illnesses which need medical treatment*" and then go on to say that it is now recognised by "*many of the general public*" that even when the disorder cannot be completely cured it is possible for the patient to live "*a happy and useful life*". The authors refer several times to the "general public" as though it was synonymous with "society" or "community" particularly when they are considering restrictions on personal liberty of sufferers from mental disorder. The most useful observation they make is about the ignorance and prejudice around mental disorder which existed then and much of which appears to be still unchanged now.

Two roles for "community care" in helping people with mental disorder are specified; the provision of services which help to prevent mental illness arising in

the first place and those which treat the condition once it has occurred. Within the preventative services there are two subdivisions: the informal and the formal. Informal services are seen as those things which help people to develop and maintain an active social life - a suggestion which appears to accept a social factor in the aetiology of mental disorder in spite of the Report's earlier unequivocal definition of it as a purely medical condition. The formal services they specify relate to support, benefit and aftercare which are unexceptionable apart from the innovative recognition that some form of family therapy and sheltered work may be needed. This tacitly admits the family as an element in their definition of "community" but here as in many other places it remains implicit and is not spelt out.

In 1961 Titmuss delivered a sceptical lecture to the National Association for Mental Health (in Titmuss, 1968) which vigorously questioned whether, at that time, the concept of community care had any reality or if it was merely a set of ill-defined aspirations. Some of his criticisms, such scattering mentally ill people into the community without adequate provision for them, have a depressingly familiar ring to our ears today. His final judgement was that getting rid of the mental hospitals was as much ideological as it was practical and ran the risk of creating less provision for mental health rather than more. Titmuss uses "community care" to mean treatment provided by clinicians and social work practitioners outside the hospital and he asks "*...could it mean that our society is increasingly unwilling to accept the responsibility, socially and financially, for those who do not recover quickly and those who do not conform to our expectations of medical productivity*?" The first point being made is that "society" seems unwilling to bear the cost of trying to treat people, in hospital, who do not respond by becoming "cured". The second point is that "community care" is a service provided outside the hospital by clinicians and social work practitioners but does not invoke any presumed therapeutic benefits provided by living in contact with the everyday world. This is a distinction which is not always made in today's discussion of community based care where there appears to be an implicit assumption that being "in the community" is to be "part of the community" and "supported by the community".

The next major policy document was the 1975 White Paper, "Better Services for the Mentally Ill", (DHSS, 1975) commissioned by Barbara Castle for the Labour Government. This paper uses the term "community" when "society" appears to be the intended meaning but offers the warning that changes should be made at a pace which allows the community to adapt to the new style of care for mentally ill people. Paragraph 1.26, for example, raises two specific issues: the changes in attitude in the community which will be needed to make the changes in provision work, and secondly the community's capacity to adjust to the implications of community care for mentally and physically handicapped people and elderly mentally infirm *(sic)* people as well as those with a mental disorder. It is also quite specific, in contrast with the broader strategic approach of later legislation, about the effects of mental disorder on the family and the consequences for employment of the sufferer and the consequences, in terms of housing and potential deprivation, of losing a job. Mental disorder is acknowledged to be destructive of social skills and relationships. Therefore, the need for social rehabilitation of those who have experienced mental disorder is specifically noted as an integral part of the move to community based care.

This definition differs from the definitions of "community" used by sociology which refers to the networks people make between themselves when living in frequent contact with each other. The White Paper has an assumption of there being a "top-down" approach in that a community is regulated by the formal structures reaching downwards from national policies which give rise to smaller scale services and authority structures which can be called "local" and therefore serve the local community. There is no recognition that rural, suburban and urban localities may have very different populations who will in turn generate and maintain local cultures with widely differing expectations and values. The existence of relatively uniform governmentally implemented authority structures and services does not mean that "community" is a unitary phenomenon for those living in it - the interaction and experience of the individual, the family and the social group are missing from the picture of community expressed in the 1959 Percy Report.

The 1975 Paper deals in detail with a range of particular issues which will need to be addressed and does not minimise the difficulties which are involved in achieving the goal of *"enabling the mentally ill to participate as fully in the life of the community"* (para. 2.24). Earlier initiatives had stressed the need for care **in** the community but thinking was beginning to move to the idea of care **by** the community. Assumptions about "community" that underpinned the Paper appear in the Act: mentally ill people will need the help of many statutory services and that those working in such agencies are ordinary members of the public and that "*their capacity for sympathy and understanding will inevitably be a reflection of the way in which mental illness is perceived by the community at large*". Changing the attitude of the "community at large" is seen as being a gradual and long-term process.

The NHS had expanded greatly since its foundation in 1948 and during the 1970s it is claimed that Government was becoming increasingly concerned about the cost of services (Clay, 1987). There appears to have been an assumption that community care would be cheaper or more cost effective than hospital care. Two of the areas scrutinised were the management of the organisation and the cost of long stay care for elderly people, and for those with mental disorders or disabilities. Much legislation and many policy directives were issued to Local Authorities and the NHS from the early 1980s, with an increasing emphasis on both administrative and financial management of services to improve cost effectiveness and efficiency of service delivery in a mixed economy of care. The changes were predicated on maximising the shift from hospitalisation to community based care for all aspects of social and health care delivery with joint working between social and health care agencies being given increasing prominence. The main areas of concern were: identifying and trying to explain the failure this far of community care, a shift from care in the community to care by the community, emphasis on a mixed economy of care and identification of LAs as the lead agency in community care (Department of Health (1990) *The Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services).*

There was a major change in 1982 when the existing Area Health Authorities were split into smaller District Health Authorities which managed all health services in their area - this was quickly followed by the introduction of general management on the recommendations of the Griffiths Report (1983) with a mandate to institute a model of management heavily influenced by the private sector. As a consequence long stay care for elderly people, and those with mental disorders or learning disabilities came under greater scrutiny. The lack of resources invested in these services was of concern and part of the rationale for emphasising community care was the perception that it would give better services for the same use of resources. A second consequence of the changes was to give prominence to administrators and doctors as general managers with nursing being given less prominence - very few senior nurses initially went into general management (Nolan, 1993). (However, in 1987, both the District General Manager and the General Manager of the Mental Health Unit in South West Durham, where the research was initiated, were male ex-psychiatric nurses, although without community experience.)

Some of the problems with attempts to move to community based care were noted in an Audit Commission Report (1986) which found that whilst the use of hospital beds was falling there had been no substantial increase in funding to local authority social care and the burden of care was being shifted to family, other carers and the voluntary sector. The operational consequences of instituting such a major change were beginning to become apparent and another report was commissioned (Griffiths, 1988) to consider ways of moving forward on the further development of community care to replace institutional care for several groups of people such as those with mental health problems and the "frail" elderly. One particular recommendation was to accelerate the rundown of large old mental hospitals with a large long stay population.

Although the 1988 Griffiths report is relatively short it identified many issues which needed to be addressed if community care was to become a viable and humane alternative to hospital care for people with long term disabling mental disorders. The major emphasis was on the need for a ministerial lead, a better understanding of the objectives of change, better organisation service delivery by

health and social care agencies with joint working between them and better funding targeted on clearly identified needs. The role of community nursing is specifically mentioned in this report as important to making the changes work.

Following the publication of the White Paper in 1989, "Caring for People" the National Health Service and Community Care Act was published in 1990. In spite of the attention and consideration that was being given to community care, it is similar to other previous policies in that it fails to define what it means by "community" and defines "community services" in Section 46(3) only as those which must be provided under the National Assistance Act 1948, the Health Services and Public Health Act 1968, the National Health Service Act 1977 and the Mental Health Act 1983. Most of the NHS and Community Care Act is concerned with the structural and financial changes to be implemented in the transition to self governing NHS Trusts and the transfer of responsibility for community care to local authorities, including service for groups who would need long term care such as people with severe and enduring mental health problems.

The field of policy and legislation is a complex one and this complexity has been evident in the development of funding sources and the structure and direction of mental health services, both in hospital and the community. The 1990 Community Care Act addressed some of these problems by specifying that particular funds would be made available for developing community based services such as the Mental Illness Specific Grant.

There is a formal requirement that Local Authorities should include a range of other bodies, as key partners, whilst drawing up a plan to assess local need and implement services accordingly. This is intended to take into account local variations in the needs of actual communities, in the sociological sense, but implies an assumption that the people in the locality served by the authority are a "community". The declared aim of the Act was to enable community participation in developing needs-led services by giving the lead for community based care to Local Authorities. The differences between the management structure and financing of NHS and Local Authorities which could be

problematic were not addressed in the Act but have been acknowledged in the literature (Hunter in Titterton (Ed.), 1994).

From the emphases and prescriptions of the documents discussed above it could be argued that the move to community care has always been motivated by considerations other than the well-being of patients moving from the hospital to the community. It has been suggested (Maxwell, 1984) that the main motive for moving to community care was to improve efficiency, and therefore value for money, by the Government. The government was also seen as wanting to do more to help people help themselves and to help families help themselves as well as to "encourage the voluntary movement and self-help groups working in partnership with the statutory services". The move to reduce the size of long stay institutions was seen as unsuccessful because the transfer of responsibilities and finance to local authorities was not being effectively managed. The NHS was seen as offering provider-determined services whereas the local authorities, being more accountable at the local level, were doing better in providing what consumers, in the community, wanted. The issues of stigma and the social control of definitions of mental illness by psychiatry were still a problem in the 1980s (Baruch, Miles in Reed & Lomas, 1984) in spite of the optimism expressed in the 1959 Commission Report about the potential to change public perception of mental disorder.

There is also an argument that in spite of the rhetoric about the economic benefit of using resources effectively, by providing community services in place of hospital based services, the appropriateness of the change has never been fully demonstrated - *"the lack of quality services for a whole range of client groups ... has been due to an inappropriate choice of model - community care*" (Baldwin, 1993). She identifies the gap between rhetoric and the level of implementation and achievement and attributes the failure of development of community services to the definition of community care as "not in hospital care" or "delivered from small units near the patient's home". A major factor in this discussion, seen by Baldwin, is the continuing dominance of the medical model of mental disorder in policy documents in spite of the evidence that much mental disorder is anything but a medical problem, and all the changes made over the last three or four

decades have supported rather than challenged this approach. One initiative, the setting up of Community Health Councils (CHCs) in 1974 to represent the interests of the population in the planning and delivery of health services does not seem to have had any major effect on the dominance of psychiatry and the medical model in the care of those with mental health problems. The CHCs have been a way of admitting members of the public as stakeholders in the design and planning of new services but the CHCs do not always seem to have had the influence on decisions which could be expected. (Tomlinson, 1991)

The emphasis on moving as far as possible to community based care for people with mental disorders was a major policy initiative but did not happen in isolation. At the time that the community care policy was being implemented there were several other policy initiatives which also impinged on CPN services. GP fund holding had been introduced in 1991 which delegated funds to some GP practices to purchase mental health care under a contract with NHS Trusts (11 of 18 practices in South West Durham had such contracts in 1995 at the time of my fieldwork). Shortly after this the document "Choice and Opportunity. Primary Care: The Future" (DoH 1996) and a White Paper "Primary Care: Delivering the Future" (DoH 1996) were published which gave details of the Government's policy for primary care to be the driving force for the NHS in the late 1990s and early 2000s.

Another policy issue has been the development of the Care Programme Approach in 1990 (DoH). This was designed to ensure that all people suffering mental health problems and in contact with either social services or health services had an explicit, documented, care plan which named a specific person as the "key" worker who had the responsibility of monitoring the client's contact with services. One aim was to ensure that clients were not ignored if they failed to attend for an appointment - particularly for those with severe and enduring problems who may neglect themselves and their medication thus leading to a relapse. Key workers are usually CPNs who then had an added responsibility to take action if a client did not make contact. This could be seen as the beginnings of a pseudo-custodial role in the community. At the same time the concept of supervised discharge and the Supervision Register was also introduced which

was intended to ensure that discharged patients, judged to be a potential risk to themselves or others, maintained their medication regime and stayed in contact with mental health services. This was never used to any extent in South Durham; at the time of fieldwork there were less than 10 people on the Register.

Since my fieldwork was done there have been several further policy initiatives which will impinge on mental health service in general and the CPNs in particular. The documents "The NHS Plan" (DoH 2000) and "A National Service Framework for Adult Mental Health" (DoH 1999) both lay stress not only on accelerated changes in the structure of the NHS but also on the development of measures relating to quality of care and on the concept of performance management which attempts to look at how well resources are used in caring for people. In addition, Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) have taken a responsibility for commissioning mental health services. However, these changes have not altered the emphasis on community-based primary care led services.

All of the policy changes and demands had an influence on the shape of community mental health services in South West and then South Durham. Pressure to move towards community based care had significant effects for CPNs in South West Durham. The population of Winterton Hospital had been slowly shrinking, particularly since the introduction of neuroleptic drugs in the 1950s. In 1952 the population had been nearly 2,500 people but in 1987 it was 1094 people of whom approximately 400 were defined as "old long-stay" patients - people who had been resident in the hospital for more than 3 years although many of these had been resident for decades (South West Durham Medical Records, 1998). One of the consequences of the Griffiths Report and the 1990 Act was to expedite the publication of an strategy for mental health services, updating the previous strategy (1986) A major part of the strategy was a plan to close Winterton Hospital (Retraction of Winterton, 1992). This document set out a formal timetable, agreed with the Regional and District Health Authorities, for implementing a programme of transfers to community based care for the long stay patients still resident in the hospital as well as eventually relocating all services to bases in the community.

A major proposal in the strategy was the further development of community psychiatric nursing services as part of multidisciplinary mental health teams (CMHTs) serving smaller areas within the District. There had been one pilot team within the District and this team formed a model for the development, from 1988 onwards, of more teams to cover the whole District. Until this time the CPNs had worked as a single service, supporting psychiatrists as well as taking referrals direct from GPs. From 1988 to 1992 they moved to work with psychologists and occupational therapists in the teams: psychiatrists remained separate from the CMHTs and continued to work from the retracting hospital.

The CPNs in the study were therefore, subject to several pressures deriving from change. In terms of the organisation there were structural and managerial changes in the NHS and efforts to develop joint working with social care agencies. Clinically, the CPNs had to cope with the transfer of previously hospitalised patients to the community, either to independent living or in small extended care units, as well as being subject to the need to take on a wide range of mental health problems referred by GPs with the underlying pressure to avoid admitting patient/clients to hospital wherever possible.

The increasing influence of primary care was felt in mental health services in South West Durham, especially for CPNs, because each fund-holding GP practice had the opportunity to negotiate a contract which they felt reflected their particular needs for services. GPs were already referring directly to CPNs, at their discretion, but some of them now wanted closer ties, preferably with a practice based CPN working under the GPs' direction. As the CPNs were part of a multi-disciplinary Community Mental Health Team this produced tensions for the community mental health service although in some cases a compromise solution was reached where a GP could refer cases to a specific CPN, attached to the practice, but with the CPN continuing to be managed by the Trust.

There were some changes in the referral pattern from GPs to the CPNs noted during this time: an increase in cases needing a short intervention particularly was found. The overall numbers were rising but this was part of a trend which

had been noted since the late 1980s when detailed analysis of case numbers began. (Korner statistics KC57 from 1986, monthly internal Board reports 1991 onwards and an internal Case Mix Survey 1995.)

Overall, there have been two main strands to the move to community care for people with mental disorders: the need to run down the old mental hospitals by transferring the long term resident patients to some form of community care, and secondly to avoid creating a new long stay population by treating new cases, as they are referred, in the community as far as possible. A major concept behind these goals, taken both from sociology (Goffman, 1961) and health literature (Barton, 1959) has been recognition of the "institutional" effects of living in a large hospital with little contact with the wider community.

Having looked at the wider context of influences on community care, the development of psychiatric nursing and community psychiatric nursing will be discussed in the next chapter.

Chapter 2: The development of community psychiatric nursing.

The "parallel strands" in the story of the development of modern mental health care.

Community psychiatric nurses work as part of a health care environment which is the end product of influences from many sources. There has been a series of changes and developments over the last half-century, which are still happening, in each of the contributory areas. One particular area has been developments in the field of community care policies as discussed in the previous section.

The development of today's mental health services is a multi-stranded story which has to consider developments in medicine and nursing, changes in government policy and in social attitudes to people with mental disorders. Contemporary mental health care has a multi-disciplinary approach which involves consideration of the mental, social and physical aspects of a client's problems. A wide range of problems are included under the aegis of "mental health" for treatment of which sufferers can be referred to a variety of services. Mental health care is not a single entity with well defined boundaries, theories, procedures and protocols in the way that other areas of medicine are, such as orthopaedics, although it could be said to still operate within the framework of the medical model with doctors and nurses as key professionals. Services have changed greatly in the past, structurally and technically, and the effects of previous change are still working in conjunction with the implementation of more recent changes.

One strand in the story is that care for people with mental health problems was for a long time a social responsibility, albeit with medical supervision of sufferers, and not until 1948 with the creation of the NHS did control of asylums pass from local authorities to the health service (Jones, 1993), Psychiatry developed as a medical specialty in the 19th century and changed greatly during the 20th century particularly with a breakthrough in the early 1950s when new drugs became available for treating the symptoms of previously intractable psychiatric problems. However, psychiatry is still beset by problems in defining mental disorder, as there are few "scientific" tests to detect the presence of

problems and progress has been limited in developing theories about the cause of mental disorder. There are debates concerning the physical versus psychological and social aspects of mental disorders, particularly about the "effectiveness" of treatment, and the management of severe and enduring disorders, as well as the control of those thought to be dangerous to themselves or others.

The development of psychiatric nursing within the field of psychiatry is another area where there have also been many changes: the emergence of mental health nursing out of the body of custodial asylum attendants, first as a ward based, medically orientated discipline then, with the move to care outside the hospital, as community psychiatric nurses working as specialist practitioners with a referred case load.

During the 20th century, other disciplines have also entered the field of mental health care: the growth of psychology as a therapeutic discipline has taken place since 1948 as has social work and occupational therapy. Each of these professional groups has its own model of human functioning and philosophy of care; there have also been various borrowings and cross fertilisation of ideas between disciplines (Nolan, 1995).

Mental health care is also very different from other forms of health care in terms of the law over the whole field of health care. There are statute laws regulating the medical profession (Medical Registration Act 1848) and the care of particular groups of patients (e.g. the Midwifery Act 1954) but mental health care also has the legal duty of restricting the liberty of individuals who are thought to be a risk to themselves or others because of a mental disorder.

There were two major changes to the law concerning mental disorder in the second half of the 20th century, the Mental Health Acts of 1959 and 1983. In parallel, during this time, the environment of care has changed from the incarceration of people with severe mental illness in asylums through the period of big, secluded and locked mental hospitals, to the late 20th century policy that people with mental disorders should live in the community as far as possible.

All of these factors have played a part in the development of community psychiatric nurses who have, until recently, trained, qualified, and gained initial experience largely in hospital as a Registered Mental Nurse, working with psychiatrists, before moving into the community to work. Here they use concepts from their RMN training and experience to which are added ideas from other disciplines, notably clinical psychology and sociology. Until the early 1990s, during training, and sometimes as an experienced nurse, although there were community placements, the dominant experience was on the hospital ward until they became CPNs. This was true for the CPNs involved in my research and was an area of interest for fieldwork in terms of the experience of making the transition to working in the community.

During the early 1990s a new nurse training programme was phased in – Project 2000. Training was moved from hospital-based schools into institutions of higher education and there was increasing emphasis on the academic aspects of nursing. There was a common path for all nurses for the first part of training. Courses then split into specialised training streams (e.g. general or psychiatric) for the second part of training. Greater emphasis was also placed on placements into a wider range of clinical environments. However, this can cause tensions and many CPNs in the study were unwilling to have students with them because of the potentially intrusive effects on clients' relationship with the CPN. (Personal communication from the Nurse Training Liaison Manager.)

Having outlined some of the factors which have helped to create and shape the CPNs' world, a more detailed discussion follows.

Mental health nursing - transition from "attendants" to "caring profession"

The history of mental health nursing is complex (Nolan, 1993) and many of the details are not germane to this work, but there are some aspects of the past which need to be teased out as they still have an influence on present community psychiatric nursing and are needed in the interpretation of the interview data. It is important to consider the development of psychiatric nursing in tandem with the development of psychiatry itself (which is discussed in a later section), as

psychiatric nurses, particularly CPNs, have gradually taken responsibility for many of the ideas and therapeutic interventions developed by psychiatry.

Psychiatric nursing did not grow in isolation but was part of the wider story of the development of psychiatry in medicine and the changing attitudes of society, and social policy, towards the care and treatment of people with mental disorders.

There are several features of the history of psychiatric nursing which are relevant for my research (Nolan, 1993). The first issue is that psychiatric nursing did not develop from the mainstream of general nursing, but from the outside when asylum attendants began to become involved with assisting doctors with the medical and physical care of people held in asylums. The early psychiatric nurse training was done by doctors, its contents determined and examined by them and psychiatric nursing has until recently remained dominated by psychiatrists. It is claimed that psychiatric nursing was until recently seen as "inferior" to general nursing by regulating and validating bodies such as the General Nursing Council (Nolan 1993). Finally, the changes to nursing created by the introduction of new elements in training, the 1982 Syllabus and then Project 2000, which linked psychiatric nursing with general nursing and which is based largely on hospital placements, have helped to create confusion in psychiatric nurses about their role in community based nursing.

To a large extent the changes mentioned above are related to other changes in the history of mental health care such as the founding of large regulated asylums in the 19th Century and the concept of the "mental hospital" following the Mental Treatment Act 1930. The creation of the NHS in 1948 was significant as it put mental disorders and their care firmly in the medical arena but did not immediately have an effect on psychiatric nursing *per se*. Pressure to move to community based care was first put forward by Enoch Powell in 1959, which included the establishment of acute psychiatric wards in District General Hospitals. Finally, the impetus of the move to community mental health care continued with community mental health teams (CMHTs) developing during the 1980s. The details of some of these changes will now be considered.

Asylums, as "mad houses", have existed probably from the 15th Century but, in the absence of any effective medical treatment, were largely intended to confine people who were suffering from a wide range of conditions which constituted "madness". (Hunter & Macalpine, 1970) As medicine developed during the 17th and 18th centuries into a recognised profession, "madness" became medicalised as doctors became increasingly employed to undertake the physical care of the inmates of an asylum. Those helping the doctors were usually called "keepers" and as early as the 18th century a Dr Battie (1703 - 1776) specified that keepers should be "of good character and intelligent, responsible people" although the opposite was the norm possibly as a consequence of low wages and the stigma attached to insanity.

During the mid 19th century legislation was developed for the regulation of asylums and, very importantly, for their funding: the 1845 Lunacy Act led to the creation of large asylums paid for by local authorities, to replace the unregulated, privately run houses. The "County" Asylums were usually run by a medical superintendent assisted by "attendants" and although at this time the women attendants were also known as "nurses" Florence Nightingale specifically excluded them from her efforts to give nursing a recognised role in health care (Nolan, 1993) .

Asylums were at that time very self sufficient and, in the past, it was not uncommon for asylum wards to be run by tradesmen who also continued to practise their craft as part of an asylum's drive to minimise the cost to county rate payers. During this period great emphasis was placed on enforcing the extensive number of rules of conduct for staff and patients in every aspect of life including the moral and spiritual (Nolan, 1993) . Towards the end of the 19th century doctors began teaching first aid to attendants as well as enough skills to assist doctors in caring for the physical health of patients. There was also a range of "treatments" supposed to help with the "madness", such as prolonged immersion in a cold bath, which were administered by the attendants after training. The impetus to train attendants was not entirely from the doctors; the attendants

themselves were beginning to push for better status and a more formal role in the asylums.

During the late 19th and early 20th century there was further pressure for a transformation from "attendant" to "nurse" although the schism between general and mental health nursing remained; when the General Nursing Council was created in 1923 the title of "mental nurse" was allowed for people working in asylums, but put on a supplementary register, not on the main nursing register. Nurses who had both general and "mental" training worked with doctors on such things as ECT, psycho surgery, insulin therapy and medication whereas those with "mental nurse" status still did the work of the "attendant" such as shepherding patients from one activity to another, overseeing the patients at work and attending to the housekeeping aspects of running the wards. The title "psychiatric nurse" was adopted informally by nurses at Cassell Hospital in the 1940s, but had no formal standing: even today the title of the basic qualification is that of Registered Mental Nurse (RMN).

There is little evidence that the creation of the NHS in 1948 had any immediate effect on psychiatric nursing (Nolan, 1993). The main effect was that psychiatry itself was now absorbed into the main health care system. Nurses in asylums had been accepted as a subgroup within the Royal College of Nursing in 1943 and there were a succession of initiatives to gain recognition for psychiatric nursing as a legitimate form of nursing both before and after the creation of the NHS. The main change was the training route for psychiatric nurses to qualify: Training had been mainly done by two bodies since 1926: the Royal Medico-Psychological Association and the General Nursing Council. However, the last training done by the Royal Medico-Psychological Association was the class of 1948 and by 1951 training was the responsibility of the General Nursing Council which in 1950 began to accept mental nurses as equals of general nurses as did the Royal College of Nursing in the early 1950s. There was still a reluctance to recognise that psychiatric nursing could have an autonomous role in the care of people with mental health problems and even in 1995 the duties of the psychiatric nurse were seen as *"overseeing patients, execution of technical nursing tasks and the general comfort of the patient"* (Prior, 1996).

There have been several subsequent major changes in the basic training of mental health nurses; a new syllabus in 1964, another in 1982 and, in the 1990s, Project 2000 where finally psychiatric and general nurses have a common basic training. The early changes were concerned largely with caring for the physical needs of patients but later changes were the inclusion of care for mental needs as well. In spite of the recent changes it is argued that even in the 1970s and 1980s (Nolan, 1993) when many of the community psychiatric nurses in the study were recruited from staff on hospital wards, medical dominance of psychiatric nursing was still marked. In spite of "enlightened" patient-centred training by schools of nursing which emphasised seeing the "whole" person, the medical model of care was at the core of ward nursing.

A second influence, which maintained the custodial aspects of the mental nurse role, was the Mental Health Acts of the middle 20th Century. Earlier Acts of 1890 and 1903 were mainly concerned with the conditions for patients in asylums, including provisions for external checks to be made on the standards of care being offered, and the funding of the asylum . Under these Acts, "voluntary" admissions could be made as long as there were family members, or friends, who would pay the cost of keeping the patient in the asylum. With the creation of the National Health Service in 1948 the asylums passed into the health care arena, from Local Authority control. The Mental Health Act of 1959 specified in detail the reasons why a person could be detained and imposed custodial responsibilities on nurses, doctors and hospital managers. However, voluntary admission was to be attempted wherever possible and detention was to be considered as the last option when there was no other course of action available. The Mental Health Act 1983 was a revision of the 1959 Act and continued to impose similar responsibilities on psychiatric nurses, although for a minority of patients.

The development of the community psychiatric nurse (CPN) began not long after the creation of the NHS and the absorption of the asylums into mainstream health care. In 1959 the *Report of the Ministry of Health* (part II) discussed the need for a mental health service beyond the hospital (Prior, 1993) although the hospital

would still be the centre for assessment and the application of nursing skills. The proposition did not include any concept of the nurse as therapist or as having specialist skills apart from nursing under the direction of the medical staff. The balance between the CPN as an independent practitioner, taking referrals from GPs for instance, and the CPN as a nurse working to the direction of a psychiatrist was still seen as a tension for community psychiatric nurses at the time of doing the fieldwork (Brooker et al., 1996).

The first CPN service was started in 1954 (White in Brooker & White, 1993) in order to help monitor and support psychiatric outpatients but the main impetus to develop CPN services came later (during the 1960s) from arguments supporting multi-disciplinary community based mental health care although at this time mental health nursing was still seen as firmly based in psychiatry. Training syllabi for mental health nursing remained firmly rooted in ward and hospital practice until the 1970s. It is argued (Prior, 1993) that changes in psychiatric thinking helped to create the opening for nurses working in the community to develop styles of care which were not based on the hospital ward. A combination of policy pressures, changes in the delivery of mental health care, the inclusion of a wider range of disorders in referrals to psychiatry and the development of new nursing models, as a response to the new demands being made on CPNs, all drove the development of CPNs as therapists. The act of seeing the "patient" as a person who is an actor in a social setting, instead of as a detached "case", created the drive amongst all nurses, particularly psychiatric nurses, to attempt to dissociate themselves from the medical model and to see nursing as having distinct goals not derived from medical practice (Reynolds and Cormack, 1990).

The numbers of CPNs have grown since their inception and it was estimated that there were nearly 5,000 CPNs in the United Kingdom in 1990 (White in Brooker & White, 1993) which is approximately 1 CPN per 13,000 persons in the population. The figures should be treated with caution as there are variations, from district to district, in the grade of nurse defined as a CPN (Ross *et al.*, 1998). The ENB currently (2000) recommends 1 CPN per 12,000 population. Locally, the definition of a CPN is a G grade nurse working in the community because they are the only ones who are authorised to do the assessment and

formulation of a care plan for each referral even if the client then passes onto the case load of a lower grade nurse. Using this definition there were 35 G grades, in County Durham in 1996, serving a population of approximately 500,000 people. This ratio is very close to the national average and only slightly less than the recommended figure for adult and elderly services.

From 1974, a specialised training year long course for CPNs became available although it was not, and is still not, mandatory for a nurse to have this certificate to practice as a CPN. It is argued that the content of the course was driven by the development of the CPN role in response to the pressures of working in the community and that by 1981 the role had been defined as: assessor and therapist to clients and relatives, consultant to other professionals and clinician to administer and monitor the effects of psychotropic drugs (Barker, 1981). At that time CPNs were still dominated by psychiatry and the needs of previously hospitalised patients.

The role and goals of CPN practice was an active debate at the time of fieldwork and three years on there still is no consensus on what the components of their practice should be (Pollock in Brooker & White, 1993, Brooker, 1995, Brooker et al 1996, Ross 1998). The advent of both community based working and accepting GP referrals for non-psychotic and relatively mild problems both contributed to a widening of the CPN role during the 1980s (White in Brooker & White, 1993). However, the introduction of the Care Programme Approach (DoH, 1990), with the existence of the Supervision Register, may be seen as an influence which will draw CPNs back into the psychiatric orbit with an increased amount of their work load being devoted to people with severe and enduring mental health problems who are under the care of a psychiatrist. At the time of fieldwork there was a management review, in South Durham, of the balance between severe\enduring cases and primary care referrals on the CPN case load with the intention of increasing the input to the former group but the issue was complicated by contractual obligations to take referrals from primary care, with relatively mild mental health problems, from fund holding GPs who provided a substantial amount of revenue income for the Trust. (Internal Management Report to the Trust Board, 1996).

There have also been influences from outside nursing and medicine on the development of community mental health nursing: the competition from other disciplines over the care of people with mental disorders: psychology, occupational therapy and social work, particularly, as care in the community developed during the 1980s and 1990s (Prior, 1993, Brooker & White, 1993). At the time of writing (2002) there is a requirement to develop joint teams offering both health and social care to people with chronic mental health problems (NHS and Community Care Act 1991, National Plan 2000). There are several issues in relation to this trend which are thought to be significant for the CPNs - who should offer care, what that care should consist of and finally to whom it should be offered (Huxley *et al*, 1998) These changes appear to be adding to the debate about the CPN role rather than clarifying it because the organisational structures within which CPNs work, the target client group and structure of clinical referral pathways are in a state of continuous change.

The history of mental health nursing has been discussed in outline because, as many of the influences and changes are still active, it is anticipated that they will contribute to the current CPN culture. Uncertainty over future goals, as indicated above, compared with other forms of nursing (Nolan, 1993) is present as are doubts about the future of community mental health nursing *per se* and whilst there is a defined development strategy there is little evidence about whether the changes will produce more effective social and health care. The CPNs are the direct heirs of many of the unresolved problems of the past: lack of a clear role for the nurse in psychiatry, lack of a clear and coherent model of human mental functioning, having no tradition of coherent development from their beginnings as asylum attendants and having moved into working in the community from a medically dominated environment.

There are other indications from research about the influences to which CPNs may have been exposed in their early years in the hospital. In 1972 Altschul found that ward nurses were using "lay" or "common sense" perceptions of mental disorder and it was not possible to discern any theoretical basis for their practice. In 1982 the training for a RMN was criticised: *"... many of the*

assumptions on which the new syllabus was based were quite untested ..... and it was not evident that the skills cited in the syllabus would indeed enable patients to get well. The syllabus did not consider that whereas nursing had been central to the practice of psychiatry in an institutional setting, it was far from clear what place it would occupy, if any, in a community setting." (Nolan, 1993, p 143). The Jay Report (1979) had criticised the poor standards of care in "mental handicap" nursing and appeared to question whether the General Nursing Council (GNC) should be supervising the work of mental nurses at all as their work was patently different from that of general nurses. The 1982 Syllabus was developed by the Mental Nursing Committee of the GNC via a panel of experts, which did not include the Royal College of Psychiatry, to develop the social and interpersonal skills in nurses which would be needed for work in the community, away from the institutional setting. Nolan argues that several specific assumptions underpinning the syllabus were untested; that psychiatric nursing was a skilled profession, that nursing competencies can be learned, and that using the skills cited in the syllabus would make any difference to the condition of mentally disordered people living in the community. It is claimed that the syllabus did not consider that whereas nursing was seen as a central function in the institution it was not made clear how it was expected to function in the community setting. The thinking behind the syllabus also appears to have reflected the way psychiatric nurses had moved from being asylum assistants to nurses concentrating on the physical health of inmates to therapeutic practitioners using psychosocial techniques.

The above issues are important as background to the fieldwork because approximately half the CPNs in the study had done their initial training before the 1982 syllabus was introduced, with the other half training after the 1982 syllabus came into use. This means that all of them had been exposed to the debates and tensions of that period during their training, particularly the issues around the kind of care which should be offered in the community and what role the CPN played.

Also, compared with general nursing, the psychiatric nurse has had, and still has, the ambivalent role of being part of the formal system for regulating and

controlling the actions of patients whilst trying to care for them and treat their problems, some of which may have been caused by the very system in which the nurses work. Working in the community adds a further dimension of having to persuade people to accept intervention in their lives without the "authority" props of a hospital ward. One key difference is that the MHA 1983 only applies to the hospital setting and cannot be used in the community.

Another current issue for CPNs is the debate, which is active for all types of nursing, over "practitioner" status for nurses with specialist skills (Walby & Greenwell, 1994). Achieving such status may be made easier for psychiatric nurses because they have a significant presence in the therapeutic and assessment processes in hospital where they could find it easier than other branches of nursing to move into the junior doctor role because there is less technology involved although such a move would not necessarily be acceptable to, and could be resisted by, consultants. In the community they have a well-established presence where they often work independently of consultants when taking referrals directly from GPs in which the GP remains the RMO and a consultant is not involved. The move towards community-based care raises more questions about the development of practitioner status in CPNs similar to that of other independent professionals such as psychologists and social workers. There are already strong links between nursing and psychology when nurses are trained as cognitive and behaviour therapists using models of functioning for interventions which owe little to the medical model.

Increasing links with social work are also part of the reforms demanded by central policy which could also blur the distinction between health and social care particularly when the overlap between the two agencies is considered. Social workers undertake therapeutic intervention as well as, for specially trained approved social workers, having responsibility for initiating involuntary committal to hospital under the Mental Health Act 1983. Community psychiatric nurses have a similar overlap; for example, when assessing the needs of carers for the elderly dementing patient they will routinely consider the social aspects of the case as well as the psychiatric and medical factors.

The material discussed thus far leads to a question as to how far the CPN culture reflects any elements of the "asylum" culture from the early days of attendants, attendant-as-nurses and then the fully-fledged psychiatric nurse working on a ward. The background for a CPN of moving from the hospital to the community raises a question about the existence of views which may compensate for the lack of a clear remit in the community and justify the CPNs' present role and status. There is some evidence (Pollock, 1993) that CPNs have a need to "justify" their work to themselves because there are no clear protocols and procedures laid down for either practice or the conditions they can be asked to treat. There is a great deal of evidence that both the practice of community psychiatric nursing and the definition of a CPN are problematic with variations from place to place. (Brooker & White, 1991, 1993, 1995, Ross *et al*, 1998). For example, the extent of links with hospital based psychiatry ranges from the CPNs being totally hospital based to a completely community based service which is separate from the ward. There are also differences in the extent of involvement with primary care: some CPNs work entirely within primary care whereas in other areas all referrals are allocated through a psychiatrist.

It is not perhaps surprising that it is difficult to define the status, role and work of a CPN given that psychiatry itself has problems in defining the boundaries of mental health and disorder, in knowing what causes problems and how to classify or label them.

Gender Issues.

Historically, nursing has been a female dominated "profession" with an emphasis on the link between the caring qualities attributed to women and the need of patients for physical care (Witz, 1992). One explanation given (Salvage, 1986) is that when nursing developed as a specific occupation the role of nurses was analogous to the role of women in society generally. She argues that because doctors came from well-to-do families, as they were the only ones who could afford the training, they expected nurses to fill the same role on the ward as their female servants did in the family setting – fetchers, carriers and carers, although this could also be applied to male servants.

The development of the practice of medicine, particularly after the 1858 Medical Registration Act which legally defined the status of doctors, has been such that doctors have always maintained power, as individuals, which has allowed them to influence the organisation of health care: in contrast, nursing has always been subordinate and relatively powerless to influence the bureaucracy of hospitals (Witz,1992). One of the reactions to being marginalised was for nurses to band together, in order to exercise some influence collectively, although this had negative effects in that the nursing culture can be seen as favouring a rigid and hierarchical structure which is not supportive of its members, in spite of the perception that nursing is firmly associated with the "caring" aspects of the female stereotype (Salvage, 1986).

Witz (1992) also suggests as nursing developed and became a defined occupation there was a "reverse" closure and gender relationships became entrenched. In the 19th century, women were excluded from learning and practising medicine, and the nursing role was defined for them by male doctors, and as a consequence of the banding together nursing became very firmly a "female only" activity. The association of "female", "caring" and nursing persisted into the late 20th century although the number of men in nursing increased, as did women in medicine. However, some attitudes appear to persist in spite of change and even at the time of my field work (1995/1996) the debate over the role of the nurse was active with some modern doctors still actively wanting nurses only in the "handmaiden" role (Barton, 1995, Bradshaw, 1995, Short, 1995).

Another aspect of the gender roles established in nursing and medicine is the perception that when men came into nursing they tend to go to the top quickly - either seeking promotion or to maximise earnings as breadwinners (Savage & Witz,1992) A second idea is that, because the NHS has always been dominated by doctors, nursing issues have never been given prominence and it has been very difficult to make changes in the identification of women with the nursing role, in spite of the increasing male presence in the "profession", perhaps because of the medical perception that nurses are "fetcher and carriers".

It is difficult to unravel the effects of nursing and gender issues when considering psychiatric nursing. Psychiatric nursing did not grow up as a specialism within general nursing but converged with general nursing at a later stage – after general nurses had fought for their status and rights. As has been shown previously, psychiatric nursing had its roots in the attendants who ran the asylum – many of whom were men – tradesmen etc who also "cared" for patients on a ward which suggests two things: men have been present in psychiatric nursing from the beginning and secondly (although not necessarily because of this) there has not been the same "closure" in psychiatric nursing by women that was found in general nursing. It is not clear from the literature how far the gender issues in nursing became associated with psychiatric nursing as it developed and attendants moved towards being regarded as nurses.

For the CPNs in the research there were some gender issues noted: in the large old mental hospitals there has been a traditional link between gender and the division of work. This division entailed male attendants/nurses running male wards and women attendants/nurses running female wards (hospital HR records). Such an arrangement existed at Winterton until the 1970s when integrated wards were introduced: there were both male and female patients and nursing staff on the same ward. The gender balance in senior nursing staff from the 1980s onwards was almost equally male and female although there was a greater proportion of women in junior nursing posts.

The Mental Health Act 1983

As a short sideways step in the story two issues in psychiatry, relevant to the research, will be noted - these issues are the Mental Health Act 1983 and the problems of defining and classifying mental health disorders.

The work of a psychiatric nurse has legally defined aspects which are unlike other areas of nursing. The nearest parallel, already noted, is midwifery where the care to be offered is defined by an Act of Parliament (The Midwifery Act 1954) but the difference is that the Mental Health Act 1983 gives powers to a

number of agencies to take away a patient's freedom to live in society and in some cases their freedom of choice about treatment.

The 1983 Mental Health Act is the current legislation dealing with involuntary admission to hospital; it deals with the reasons for such an admission, the procedures which must be followed to validate the use of the powers, the safeguards for patients and the appeals procedures against the application of the Act. (It also defines the responsibilities of those using the Act towards a detained patient. (Appendix 1 gives a more detailed summary and discussion of the Act.)

The Mental Health Act 1983 only applies to patients in hospital who need to be detained for assessment or treatment because they are judged to be a risk to themselves or others by reason of a mental disorder (with some specified exceptions: detention cannot be imposed for untreatable personality disorder, sexual orientation or drug/alcohol abuse). The act is invoked mainly by Authorised Social Workers, GPs and/or consultant psychiatrists although there are provisions for nurses to detain at-risk patients in hospital, against the patients' wish to leave, in the absence of a doctor. This means that much of the psychiatric nurses' work in hospital is with patients who may not wish to be there and who may have to be restrained from attempting to leave: even those who are not detained under the Act may fear compulsory detention if they try to discharge themselves without medical sanction.

Many patients detained under the Act need constant observation, which means that a substantial part of the nurses' time is spent ensuring that a patient does not move out of their sight. For instance, an analysis of acute wards at Winterton Hospital for the month of March 1995 (operational project - unpublished) showed that on occasions there were as many people on observation as there were qualified staff on duty. This meant that those who did not need to be kept under observation could only receive the minimum attention from qualified staff and that the burden of care for "safe" patients fell to less qualified staff.

All of the nurses in the study had worked with either the 1959 or 1983 Acts during their time as ward nurses and whilst the MHA does not apply to work in the community some of those with whom they work in the community risk compulsory detention if they fail to "comply" with their care plans as do voluntary patients in the hospital. However, for all CPNs, the legal aspects of care were an active part of their work during their training and hospital-based experience. This applies both to experience on acute wards and on other long-stay wards. Therefore, one of the questions of interest is how much influence from hospital experience of at-risk patients has been carried over into CPN views and how they handle the "risk" aspects of caring for discharged psychotic patients in the community who remain at risk of the re-imposition of detention if they have a crisis or re-lapse in ways that bring them within the remit of the Act.

Problems of definition and scope in psychiatry.

One of the biggest problems for psychiatry and mental health care has been, and still is, the major issue of what *is* a "mental disorder" (Prior, 1993). This is of significance for CPNs in terms of defining their client group, what are legitimate problems for CPNs to treat and what the treatment should be.

Medicine is based on biology of the human being, particularly anatomy and physiology. Problems are described and explained, for instance, as a pathological biochemical malfunction or invasion by micro-organisms. In the case of psychiatry there is an ill defined mix of physical and non-physical (i.e. psychological) problems which are largely identified and classified by reference to the sufferer's behaviour and thinking (Kendell, 1991). There are few observable physical signs which can be linked to a known organic functions. The causes and workings of many mental disorders have no satisfactory explanation which makes devising treatment a problem, particularly when using drugs to treat symptoms.

In the literature there is a variety of terms in use (Brussel & Cantzlaar, 1987, Campbell, 1981, Cockerham, 1981, Walton, Beeson & Scott, 1986, Gregory, 1987, Mental Health Act, 1983, Gelder et al, 1991, Kendell & Zealley, 1993) -

mental health, mental illness, mental disorder, behavioural disorder, disturbance of conduct. To confuse matters even further, when two different authors use the same term it does not always follow that they are using the same definition of that term. The main significance for this thesis is that this melange of terms appears to indicate real and abiding differences in views about the role played by the mind, and thought, as opposed to physical and physiological malfunction, in the conceptual schemes which underpin the cultures of the various professional disciplines involved in caring for those with mental health problems.

There has been much criticism of the "medical model" view of human mental functioning when applied in psychiatry often seen as starting with Laing (1965, 1971) and carried on by Szasz (1973, 1974). My early work with the CPNs in 1987 indicated that they have strong views on this topic and it is an active debate. The exclusive emphasis on a biological explanation, as the medical model appears to be, of mental disorders was seen as excluding "mind", and social factors, from therapy which reduced the client to having a passive role in their recovery rather than having an active and dynamic part to play in treatment of the problem.

Many definitions in the literature state "mental health" is the concern of the "behavioural" sciences which suggests that it is of concern to a wider field than psychiatry and that, secondly, a mental health problem is defined by reference to a culture's norms. This further implies, by extension, that as social attitudes change the definition of a mental health problem can change (Prior, 1993) and that those with "mental health problems" may not necessarily be "mentally ill" as people with psychosis , for example, are seen to be. This is important to the thesis because of the issue of "what is an appropriate client for a CPN to treat?"

The picture that emerges is that mental "disorders" may be seen as biologically and/or socially determined, either organic or non-organic (functional) and may be detected by the presence bizarre or irrational behaviour of the sufferer (with reference to society's norms but the criteria for comparison are often implicit and are not always defined). Almost the only point of agreement in these definitions

is that there are a group of people who suffer from some kind of disturbance which may cause distress to themselves and/or others.

It was not until the latter half of the 19th century that psychiatry emerged as a separate medical discipline with its own field of study (American Handbook of Psychiatry Vol. I, 1974) with Freud often seen as perhaps the most influential of the "founding fathers". Formal labelling of psychiatric conditions started in the late 19th century with a scheme intended to be "systematic", developed by Kraepelin. The late 19th century was a time of great developments in anatomical and physiological studies and is thought Freud saw his work as comparable in developing a biological theory for mental functioning. Later, post-Freudian, psychodynamic workers sometimes widen their horizons by allowing the social environment to have more influence than did the original theory (Fadiman & Frager, 1976).

There are thus many tensions and conflicts within psychiatry as to what constitutes a psychiatric condition, what causes it and, following from this, how and whether it should be treated. There is a wide range of views and philosophical positions which range from the anti-psychiatry position of Laing (Laing 1965, Laing and Esterson 1970) through to those who would like to explain all behaviour as a consequence of physiology and biochemistry (Zeally, 1993). Some authors on psychiatry are able to find reasons to accept that the medical model has to co-exist with other positions, in spite of the unconformities and tensions that this strategy engenders (Prior, 1983). There is, therefore, by definition, a risk of potentially inappropriate responses; using the medical model to treat the symptoms of problems which may have a psychological or social origin, using psychodynamic interventions which are predicated on a biological theory of maladaptive development.

In practice, the care of a person on a ward in a mental hospital is based on the psychiatrist's diagnosis and prescription of treatment and care in terms of medication protocols and assessment of risk of self harm or harm to others. Psychiatric nurses also make their own assessment of the patient's psychological, social and physical needs which then constitutes the patient's care plan but the

nursing care plan cannot override or alter the psychiatrist's prescribed care of the patient. For instance, the psychiatrist's assessment can require constant observation or can lead to loss of liberty and choice for the patient if they are detained under the provisions of the Mental Health Act (1983). If the patient is seen as needing treatment against their will, and has been detained under the relevant section of the Mental Health Act 1983, this can be done and the nurse must follow the psychiatrist's instructions. This hierarchy of care raises a question as to whether diagnostic based labels, and the use of the Mental Health Act 1983 create views for nurses about the nature of the disorder and the patient's ability to function rationally.

In the community, South Durham CPNs feel they do not always have a specific diagnosis for many of the problems referred to them by GPs (Report to the Trust Board: CPN Case Mix and Case Load, Price and Ellis, 1995). For this group of clients the CPNs have to find alternative ways of assessing the client's problems and formulating the appropriate response, which may on some occasions mean referral back to the GP for care by another professional group. This issue helped to formulate one of the original questions for my research: how do nurses make the transition from the medically dominated ward situation, with formal diagnoses, to the community situation where problems are defined by the client and there is no psychiatrist involved in many of their cases? What views do nurses take with them to the community about how problems are classified or categorised? And how are those views modified as nurses gain experience as CPNs?

The influence of clinical psychology.

Another influence on the development of community psychiatric nursing has been the theories and practice of clinical psychology, particularly for CPNs the emphasis on "client centred" work (Nolan, 1993, Gijbels & Burnard, 1995).

A psychologist may be involved in the treatment of psychoses but this group of problems is normally left to psychiatry at the inpatient level. For people with a diagnosed psychiatric disorder living in the community a psychologist may be

part of the team helping to maintain life-skills and the social stability of the patient. The so-called "neurotic" problems are the main group of problems referred by GPs to psychology - anxiety, some forms of depression, self abuse, obsessive-compulsive disorders. As the CPN service developed GPs began to also refer people with these types of problem to CPNs. Such problems are not well represented in the referrals to hospital based or out-patient psychiatry and therefore an RMNs' therapeutic hospital based repertoire and experience was not likely to include techniques for treating the problems referred by GPs. It is argued by Prior, (1993) that CPNs borrowed techniques from psychology for treating many of these cases.

Having examined the influences on the development of the CPN service the next section will consider the literature on some aspects of CPNs' work.

Issues in Community Psychiatric Nursing.

Apart from issues which had been noted for further exploration in my earlier work with the CPNs in 1987, there were many pointers from the literature to possible areas to explore in the fieldwork. Attention has been drawn to the mixture of "psychiatric" versus "psychological" problems, which can be found in the CPNs' workload, in terms of the consequences for their perception of their role and their remit. This can also be seen as a tension between medical perceptions in primary care and secondary, hospital based care. The CPNs can be seen as having to make a transition from working with psychiatrists in hospital to working with both psychiatrists and GPs in the community.

The case mix of psychiatric and psychological problems in referrals made to CPN services, has been noted as a general feature (White in Brooker, 1990) - in particular the increase in GP referrals to CPNs which do not involve a psychiatrist. Psychiatrists have also been noted as finding this process unwelcome and they have not generally been enthusiastic about community psychiatric services developing in the community unless they are running them. Tensions have been found in CPN services because CPNs have to accommodate the interests of both psychiatrists and the increasing dominance of GPs, both for

the good of their clients and for the CPNs' own professional standing (Prior,1993).

White (in Brooker, 1990) also found a related tension in that CPNs are "tugged" between the care of people with chronic and enduring mental health problems, who are seen as not rewarding because of the intractability of the disorder, and the care of people with short term problems who can be "cured" quickly. The need to demonstrate that effective outcomes are being achieved means that people with short-term problems are seen as rewarding because they show progress quickly. However, "quick fixes" are not seen by consultants as a high priority for what are scarce resources. There is an association of the long-term patient with psychiatrists and the short-term client with the GP, who needs to be convinced of the usefulness of the CPN service, especially if, as a GP fund holder, payment is involved as it was during the time that the research was designed and the field work carried out.

Monkley-Poole, (1995) found that with the development of GP fund holding in the 1990s, GP attitudes to CPN services are favourable and that they would like CPNs to be practice-based. It had been suggested earlier, before the advent of fund-holding, by Pollock, that was a likely direction in which CPN services would eventually evolve anyway (in Brooker, 1990). GPs are also seen as becoming gatekeepers to all community based services and therefore in a position to influence the work of the CPNs (Monkley-Poole, 1995). However, detaching the CPN from the psychiatrist and the hospital, coupled with a lack of research on the effectiveness of CPN services, creates problems for the CPN in retaining, or achieving status as practitioners rather than becoming another "nurse" on the primary care team and therefore just another member of the primary care team.

When comparing social workers with CPNs, in the care of people with mental health problems in primary care, Sheppard (1992) found that CPNs made more contact with GPs than did social workers, usually initiated by the CPN, and that GPs seldom initiated the contact themselves. This appeared to be in spite of an increased level of referrals to CPNs by GPs. CPNs were also more likely to give

case based information to the GP although GPs were more likely to influence a social worker's practice than a CPN's. However, it has been found that the GP has an strong influence of the work of the CPN indirectly because the CPN case load is determined not by clinical criteria but develops from local need as perceived by referring agencies – particularly the GPs (Pollock in Brooker, 1990). At the time of my field work there were no agreed clinical criteria for GP referrals to the CPN service (Management Report on Referral Pathways, Bilbé,1994)

A research project (Prior, 1993), involving both patients and CPNs, shows that the mental-illness-medical model and the mental-health-problem-psycho-social-model link is found both as a distinction for the approach to care and as an explanation of the cause of the problems. If mental problems are seen as an "illness" they are perceived as caused by biochemical problems and the response is a "medical" one - usually involving prescribed drugs with the sufferer seen as a "passive" patient. If mental health problems are seen as "psycho-social" malfunctions the response is to see the sufferer as an active agent and to treat the problem by encouraging the "patient" to make changes in their thinking. This is linked in the literature with a change in nurses' views on cause and treatment in the transition from ward-based hospital nursing to community based nursing involving a wider range of problems - i.e. the hospital has tended to be dominated by the medical model whereas in the community there can be a wide range of problems, causal explanations and treatment.

Psychiatric nurses in a hospital are also seen as suffering a similar poorly defined situation in terms of confusion about their role between either "carers" and therapists, or both, (Gijbels & Burnard, 1995) without a clear theory of nursing. This observation suggests that when nurses move to the community as CPNs they are not always moving away from a clearly defined role in the hospital to a less clear role in the community. The difference appears to be between moving from a nursing role closely dominated by psychiatrist-driven routines to a community role with less medical dominance and a different regime.

The literature has studies on issues relevant to the problems of transferring from working as an RMN on a hospital ward to working as a CPN in the community.- lack of suitable education and training (Pollock in Brooker, 1990, Barker, 1989), lack of a coherent theory of CPN practice (Prior, 1993, Pollock in Brooker, 1990, Gijbels and Burnard, 1995), lack of information about the effectiveness of CPN practice (Pollock in Brooker, 1990, Brooker, Repper and Booth, 1996), role conflict and no formal definition of a CPN's remit, (Gijbels and Burnard, 1995) and a relatively unsupported view that "community" care is desirable (Prior, 1993, Baldwin, 1993, Bulmer, 1987, Hunter, 1994 Tomlinson, 1991, Scull, 1983). Taken together this material suggests that CPNs work in a situation where the problems they have to treat, the means of treatment and the desired outcome are all poorly defined. It is not clear how generally the findings apply because of the differences between CPN services and their work, in different areas of the country, already noted above. However, many of the aspects of the CPNs' work appearing in the literature were explicit issues for CPN services provided by South Durham Trust at the time of fieldwork and were issues in management discussions.

Generally there is no consistency in the CPNs' "remit" between organisations employing them. (Ross et al, 1998) There are rules for conduct and organisational matters such as hours worked, timekeeping and so on but there is an absence of a generally agreed target group for care and what the care should consist of. This situation is similar to that of many other workers who have to apply bureaucratically determined "rules and procedures" about the organisation of their work, in the real social world (Lipsky, 1980). Formal and stated policy intentions of the organisation may be "re-interpreted" or even subverted to make them applicable and workable by those at "street level" who have to put the policies into operation. In the case of the CPNs, with few definitions about what they actually do for the client, the policy is sometimes so ill defined, in operational terms, that they have not so much as to re-interpret as interpret it in the first place. It can be seen that without specified status and role, CPNs may have to protect and, if possible, enhance their professional status on order to have the authority to work in the way they believe is appropriate for their skills and experience. The CPNs are not working towards a clearly defined set goal but are

taking on board changes as they happen and are accommodating them into their world on a relatively ad hoc basis in the way Lipsky (1980) has found in a range of public services in America.

A significant issue found in the literature concerns the assumption that community based care is the best and most humane way of treating mental disorder wherever possible. (Pollock in Brooker & White, 1990) The general view is that community care is "good" and hospital care is "undesirable" except for people who are at risk of harming themselves or others. That the "community is good" may not be valid, and that there is the possibility of "community as an institution" (Prior, 1993), is a fundamental challenge to the purpose of having CPNs for providing care outside the hospital to avoid institutionalisation. There appears to be an implicit assumption that the concepts "institution" and "community" stand at opposite ends of a scale of empowerment and freedom for the individual to act out his/her life. The idea that the living in the community does not automatically confer empowerment and freedom of action on the social actor is not always apparent.

Similarly, another topic was suggested by the finding (Prior, 1993) that CPNs seek to empower people seen as damaged by previous institutional treatment for their mental disorder or to avoid this happening by only seeking admission to hospital at times of risk. Some CPNs saw this as an "ideal" rather than practical aim but were nevertheless committed to it. However, this raises a question about how far the CPN plays a pivotal role in the potential admission of a client to hospital and what influence their belief in the value of care in the community plays.

In spite of the commitment found in my previous work among South West Durham CPNs to keeping clients in the community, and out of hospital, it is argued that the CPNs may be as acting as "gate keepers" between the community and hospital at times of crisis (Morrall in Purdy & Banks, 1999). Their commitment, previously noted, to the perceived benefits of living in the community may be tempered by the need to control "risk" and there is the possibility of erring on the side of caution in case a person in the community

comes to harm, or harms someone else, which could call the CPNs' clinical judgement into question.

This role applies both to those with severe and enduring mental health problems, who are to be maintained outside the hospital as far as possible, and to those with more transient, if acute, problems of adjustment to adverse life situations who are to be kept away from the hospital to avoid institutionalisation. It could be argued that CPNs are colluding with psychiatry in excluding those with mental disorder from society because the CPN is the judge of level of "normal" functioning in the client who can be admitted to hospital, taken out of the community, when the client appears to be irrational. The decision to hospitalise a person is taken by the RMO (either the GP or the psychiatrist) but the CPN is instrumentally active in both situations because it is their responsibility to monitor the client's progress, or lack of it, and to alert the RMO especially in cases where there is a perceived risk of self harm or danger to others. Given that psychiatry was to a large extent hospital based, in South Durham, and also that GPs are not well trained in dealing with mental health problems, this places a particular responsibility on CPNs and gives them a significant role in shaping the client's life. The CPN can be seen as having increased influence when the case has been referred by a GP who may rely heavily on the CPN's advice concerning a referral for hospital admission. However, if the CPN is monitoring a person who is still under a psychiatrist's care the CPN's judgement may have less weight.

In a second way the CPN can be seen as a "gate keeper" to the community in the sense that the CPN may constitute the only link with the community for some clients because the level of contact with the wider community for people with mental disorder living there can be minimal. They can in some cases be regarded as living in a virtual institution in the community with only the CPN's visit for contact (Prior, 1993). Particularly where the client has been isolated in a mental hospital for a long time and lost contact with the wider community the CPN is the bridge between the client and the strange world in which they can find themselves when moving to community based care.

Taken together, all of the above material suggests that the CPN culture may reflect many of the tensions already noted and that there may be generally held views about such things as the role of the CPN in the community and relationships with other disciplines, models which define the nature of the problems they are treating, and, in particular, ideas which will explain, compensate for or deny the many uncertainties in their working life.

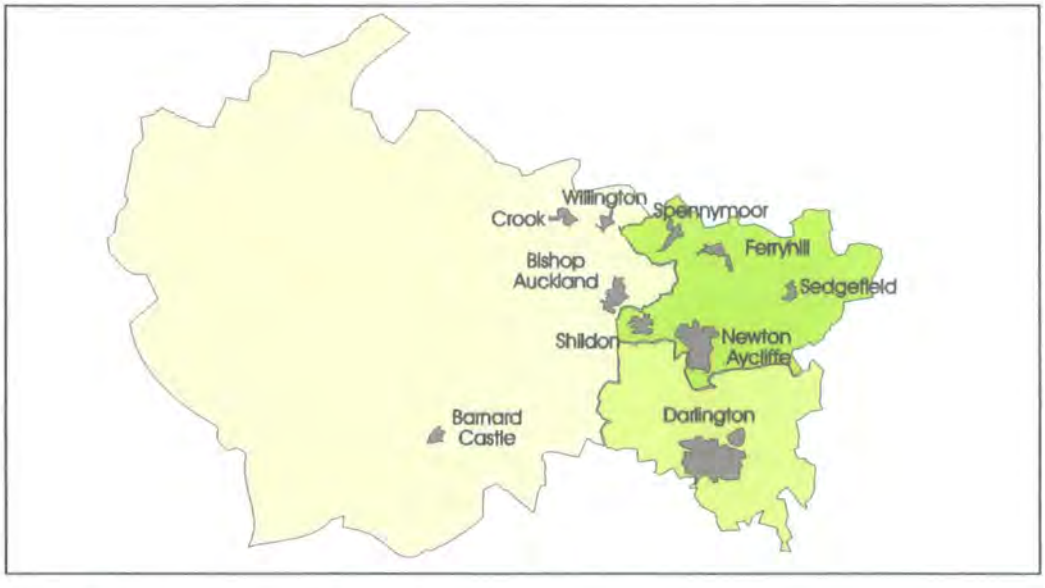
The role of the CPN as an agent of the institution, perhaps unwittingly so, is highly relevant to the research. If a CPN has to make decisions about the client's condition, such decisions could lead to significant changes in the client's social and community life. Therefore the nature of the CPN's views about the value, or otherwise, of the institution is important in terms of their practice and their culture.

Having reviewed some of the issues relating to the CPNs' work, the setting for the research now needs to be discussed before moving on to the work itself.

Chapter 3. The research setting.

Geographical and population features of the catchment area from which the sample of CPNs was drawn for interviews need to be discussed because they have to some extent imposed a particular style of working on the CPN service.

When the research began it was intended to study the CPNs working for South West Durham NHS Trust, a mental health unit, based at Winterton Hospital near Sedgefield, which provided full hospital and community services for the Local Authority (LA) areas of Wear Valley and Sedgefield with some limited hospital-based services for surrounding areas. During the early part of the work South West Durham merged with South Durham Health Care NHS Trust to form South Durham NHS Trust which then served Wear Valley, Sedgefield, Teesdale and Darlington Local Authority areas. After data collection, at the beginning of writing the thesis, a further merger took place to include all of North Durham apart from Easington. The final merger will not be discussed as it took place after my fieldwork was finished.



South West Durham and South Durham Catchment Area (1996)

The population of South West Durham was 153,254 at the 1991 OPCS Census and projections forward, using standard survival tables, to the time of the study showed little anticipated change in overall numbers. The net effect of migration

could not be estimated with any degree of reliability although a comparison with the 1981 OPCS Census showed little change in overall numbers which suggested that large scale migration was not a major feature. The age and gender structure of the population was very similar to the national picture. The population numbers were projected forward using survival tables to show that the main anticipated changes, between the 1991 Census and the end of the 20th century, are a rise in the numbers of extremely elderly people which was expected to put increasing pressure on those CPNs who treat the elderly.

All of the following information was taken from the 1991 OPCS Census and was analysed using software which mapped the population at ward level (Map91, Supermap).

The population lives in a mixture of small to medium sized towns, villages or scattered in hamlets and isolated dwellings. The largest town, Bishop Auckland, with approximately 38,000 people (about 25% of the total population) is in the middle of the catchment and is the site of the District General Hospital To the west, through Wear Dale, is a series of small towns shading to smaller villages to the extreme west, scattered over a large, sparsely populated rural area. To the east the area is more compact with the population mainly living in a number of villages. The catchment area is much wider east-west than it is north-south.

Overall, the west of the catchment has a higher proportion of agriculture and a lower proportion of industry, whereas the opposite is the case for the centre and east which have some agriculture but a higher proportion of industry, based originally on mining for many small communities such as Fishburn, Tudhoe and Trimdon.

In 1996 South West Durham merged with another Trust to form South Durham which added Darlington and Teesdale to the catchment, increasing the population being served to 276,250. Darlington is very compact with approximately 90% of the population of the local authority area living in the town with the remainder living in a very small surrounding rural area. Teesdale is at the other extreme as it forms 48 % of the total land area of the catchment but only has a population of

24,068 which is 8.7% of the total. As with South West Durham, the western part of South Durham, Teesdale, has a higher proportion of agriculture, although there is also a large dormitory population and an excess of older people who are thought to have retired to the dale. There is only one town with a population above 3,000 which is Barnard Castle at about 5,000, projected forward from the 1991 Census to 1996. The remainder of the Teesdale population are the most isolated in the catchment, living in very small villages or farms in the rural area.

One other demographic feature which is of interest because of its links with poor physical and mental health is deprivation (BMA, 1995.). South Durham has some of the most deprived areas as well as the least deprived areas in what was then the NHS Northern Region (Phillimore and Beatty, 1994, DETR Deprivation Study, 2000). Using electoral wards to divide the catchment, the worst areas are in Bishop Auckland (Woodhouse Close) and Darlington (Firth Moor and Skerne Park). There is also some moderate deprivation in the two dales areas such as in Cockfield, to the west of Bishop Auckland and in upper Teesdale in the Middleton in Teesdale ward. Barnard Castle also has one ward, of two representing the town, where there is a moderate level of deprivation. The levels of deprivation were associated with above average levels of unemployment in some wards and with social class. Although class numbers are generally similar to the national picture the distribution of people by class was patchy. For example, in some wards the residents were largely in the more affluent classes whereas in other areas, particularly the deprived ones, the population was largely from less affluent classes. Dormitory villages in the rural areas tended to have a mixed population of relatively affluent incomers and an indigenous less affluent population. It was found (Price & Bilbé, 1996) that there was a higher level of referrals from areas with higher deprivation and the CPNs were familiar with particular areas as "hot-spots" of need for mental health services..

The structure of mental health services and development of CPN services.

The original intention was to use the South West Durham CPNs for the research but as a merger took place with South Durham Health Care before data collection began it was decided to include the South Durham CPNs in the work for several

reasons: it provided a larger group for data collection and the two CPN services had different origins and histories so the inclusion of both groups could possibly provide data about the extent of local influences in the views of the CPNs involved.

Much of the information about the early years of the CPN service was gathered in interviews with the two managers who founded the services in South West Durham and South Durham respectively, because much of the relevant early documentation was lost or irretrievably buried in large unindexed archives. Some information for South West Durham was available from my 1987 research and from operational knowledge and experience of working with clinical services in my role as Head of Information (1991 - 1996) which had involved both routine collection of activity data and analysis of this and other data for management purposes. For South Durham information was less freely available and there was no experience of working with this group, therefore the majority of the information came from the manager who had started the service.

In South West Durham mental health services were centred on Winterton Hospital, outside the village of Sedgefield near the south east boundary of the catchment area. Until 1998, the hospital had facilities for acute psychiatry, long stay wards, and wards for people suffering from psychiatric problems of old age. There were units for day care, specialist assessment of the elderly and a secure unit for disturbed adolescents as well as a school of mental health nursing until 1994. The acute, long stay and elderly facilities were used by North and South Durham until the retraction of the hospital began to gather momentum in 1992 when surrounding health districts began to develop their own facilities for psychiatric care.

Because the hospital was not central to the main population areas the first 11 South West Durham CPNs, in 1976, were attached to social services and community nursing sites throughout the area. The team manager was responsible to the Director of Nursing for the work, conduct and management of the team. By 1984, the CPN service were managed from a team base in Spennymoor Health Centre: between 1986 and 1992 the CPNs in the team were gradually

transferred to the multi-disciplinary community mental health teams (CMHTs), as they developed, where the CPNs worked in teams with psychologists, occupational therapists, physiotherapists, social workers, junior grade psychiatric nurses, care assistants and sometimes dieticians and art therapists. The development of CMHTs enabled the CPNs to work more closely with colleagues in other fields but also possibly engendered tensions about their status and independence.

The development of CMHTs began with a site in Crook and then was extended to Newton Aycliffe, Spennymoor and finally Bishop Auckland - each CMHT site served the surrounding area although at first boundaries were not rigidly defined. Each team was managed and co-ordinated by a senior grade CPN who in turn was managed by a locality manager, responsible for all types of service (i.e. for services devoted to people of working age as well as those over 64 - a distinction made by the Department of Health) in a particular geographical area. During the period 1989 to 1994 the CPNs who cared for people over 65 stayed together as a single unsectorised team under a specialist team leader but in 1994 they were dispersed to the CMHTs as specialist nurses for the elderly becoming responsible to the CMHT team leader for their day-to-day work but with input from a nurse designated as a Trust-wide clinical leader in nursing people with the psychiatric problems of old age.

The original intention was that SW Durham CPNs would provide nursing care and support for people with chronic mental disorders who were discharged from the hospital to live in the community. Some of the CPNs who were part of the original team and who were interviewed in the research can remember no documented remit being given to them - the general response was that they were "making it up as they went along". This is supported by the literature as a common feature of early services (Brooker & White, 1993). However, from the beginning they were also able to take referrals directly from GPs without a psychiatrist being involved. Psychiatrists were not part of the CMHTs, but maintained a separate presence in the community through out-patient clinics for patients, also referred by GPs. Because they were in the community, CPNs began to get referrals from GPs for problems beyond those which would normally have

been sent to psychiatry, for which CPNs' hospital nursing training and experience had not prepared them.

There were many opinions amongst CPNs in the 1987 research (Bilbé, 1988) as to why GPs chose to refer cases to CPNs which they would not refer to a psychiatrist - one of the reasons offered was that GPs found the waiting time for referral to psychology too long and therefore referred to CPNs instead. Little accurate information was available about referral patterns beyond an in-house case load survey which showed that approximately half the case load were people with chronic psychiatric problems and the other half were people who had a mixture of mild psychiatric problems or one of a variety of psychological problems, some of which could be severe. (At the time of doing this research, the mixture of long term versus short term problems on CPN case loads was an active management issue.) The issue of legitimacy of referral was noted as a possible question for the research interviews because there was no explicit protocol for referrals. This linked to my research questions about how the CPN moved from the hospital, where referral and admission were decided between various external agencies and psychiatrists, not involving the RMNs, to the community, where the referrals were from GPs and other agencies and were accepted or referred back by the CPN.

In South Durham, centred on Darlington, the service had been hospital based at its inception and worked directly with psychiatry at first to provide community psychiatric nursing for people with chronic and severe mental health problems although GPs could refer to the service. When the South Durham CPNs moved to community bases during the 1980s, they did not work in multi-disciplinary teams but remained a single-discipline service.

At the time of data collection there were two teams in Darlington, one for people between 16 and 64 and one for people over 65. These were based in the community but maintained strong links with the psychiatric unit at Darlington Memorial Hospital nearby. A third team was based at Barnard Castle Health Centre, which took referrals for all ages.

As there are large national variations in what CPNs are asked to do for patients and for the type of patients they have referred to them (Brooker & White, 1993), it was not assumed that the South Durham CPNs would accept referrals for the same problems as South West Durham CPNs do and this was also noted as a possible topic for the interviews. The merger of the two Trusts did not change the structure of the service and during the two years of its existence, when data collection took place, South Durham Trust operated with multi-disciplinary CMHTs in the north of the catchment (Wear Valley and Sedgefield LA areas) and single discipline teams in the south (Darlington and Teesdale LA areas).

Government policy, particularly the development of care in the community, which had a major influence on the structure of services immediately prior to the period of the study, was having an effect on CPNs during the data collection period. The broad thrust of the policy has already been discussed in a previous chapter but some of the specific consequences, in South Durham, of policy on community care and the changes to funding in the NHS need to be outlined.

One of the main effects was the change in funding for CPN services. At the time CPN services were developed they were paid for by the District Health Authority as part of the mental health unit's overall budget. During the early 1990s the change to commissioned services provided under contract allowed GP Fund Holders (GPFHs) to purchase CPN services from their own budgets with non-Fund Holders' use of services paid for by a contract between the Health Authority and the Trust. This caused a change in the pattern of referrals from GPs with a greater number of people with acute situational reactions being referred, particularly from GP Fund holders. At that time it was Unit, and subsequently Trust, policy to accept all GP referrals at least for assessment and then, if suitable, for referral onwards to other agencies. (internal management monitoring information 1991 -1994, collected to supplement Korner Returns which did not have this level of detail).

At the same time the policy emphasis on retracting mental hospitals and minimising length of stay for new patients was pressurising GPs only to refer people to psychiatrists when absolutely necessary - one of the GPs' reactions was

to use the CPNs to assess cases on an urgent basis to assist the GP in deciding where the referral should go.

Summary of CPN Activity in South Durham at the time of field work - 1995/1996.

The information for this section was taken from data returns made annually to the Department of Health (Korner Returns KC57, 1995, 1996). These returns summarise the number of referrals and subsequent activity by CPNs.

The 35 CPNs in the study and their supporting nurses/care assistants, worked in 8 teams. The number of support workers per CPN varied for several reasons - the type of work undertaken by the CPN, historical staffing levels which had not been changed and whether the CPN was practice based or based in a CMHT. All referrals were seen by a G grade CPN for assessment and care planning and then some of the care was delegated to support workers. In 1995/96 the CPNs and their support workers provided 39,300 face to face visits for approximately 4,200 referrals – 72% of the visits were in the client's own home with the remainder being mainly on NHS premises, usually at the CMHT base. Of the referrals, 3,100 were people who had never needed care from the CPN service before and 1,100 referrals were from people who were already known to the service. GPs referred 88% of the cases with the other 12% being referred by a variety of agencies such as psychiatrists, health visitors, district nurses and social workers.

For most CPNs, the active case load (the number of clients who were being seen at any one time) was about 45 – 50 people with an average of 10 visits per case although this can be misleading because a substantial number of people only receive one or two visits but a substantial minority are seen much more than average (Price & Bilbé, 1996). An analysis of the case load suggested that there were three main categories of client referred to CPNs. Those who were assessed and then referred to another agency would have only one or two contacts, those who had a mental health problem which needed psychosocial intervention would have a moderate number of contacts and finally people with severe and enduring

mental disorders did not necessarily have frequent visits, but remained on the case load for a long time.

The objectives for my research were firstly to identify and then explore any views held in common by a group of CPNs about their professional world, and the extent to which these could be seen to reflect a set of values which could be described as a 'culture'. The second issue of interest was how the culture reflected the experience of initial training and working with inpatients in a mental hospital before the nurses moved to the community as CPNs. The topic developed out of earlier work (Bilbé, 1988) when a small scale project suggested that CPNs believed that they acted in a social context not understood by other workers in the field of mental health care, particularly nurses and managers who were still based in the hospital. During this project the CPNs were asked a general question about the issues facing them at that time. Several points were consistently made which were then explored in a group discussion where it appeared that there was a consensus that being a CPN was very different to working in the hospital setting.

A major view was that the hospital was an outmoded institution which created dependency in patients and this in turn created the so-called "long stay" population for whom the hospital was doing little to rehabilitate them to everyday living. A second and connected view was that the management, nurses and doctors working in the hospital had little idea about what it was like to care for people in the community. This view had several components: what it was like for the patient to live and be cared for in the community, how the CPNs provided care and what it was like for the CPN working away from colleagues, in relative isolation. There were comments about hospital based nurses being seen as thinking that "*CPNs just sit about chatting to people and drinking tea all day*". A CPN of long experience used the metaphor of the hospital as the "*big house*" and the CPNs as the "*toilers in the fields*" - when pressed the comparison was expanded to indicate that the CPNs felt that their work was not seen by managers and hospital based nurses and doctors as important compared with the serious business of caring for in-patients.

CPNs in the survey had made passing mention of Goffman's (1958) concept of the "total institution". I had read the work as an undergraduate but now re-read the work in the context of the experiences of the CPNs and several questions began to emerge. Goffman's work suggests, in particular, that staff have an understanding of the hospital derived from its function and purpose as defined by those responsible for managing the hospital: those "in authority". For example, the staff assumed that because a person was committed to the hospital they were *de facto* "insane" and therefore it was acceptable to treat them according to the dehumanising processes of the hospital. Goffman also suggests that the understanding of patients and staff of the situation are separate even though both are derived from the same situation. The views of each group are separate in the sense of seeing the situation from a different point of view. For example, patients may interpret staff actions differently from the intention of the staff concerned. I felt that this idea could be used to ask about separate understanding of the CPNs' work by CPNs and hospital based nurses, because attitudes towards patients and managerial control of nurses working in the community appeared to be less rigid and prescriptive. For both nurses and patients the "rules" of providing and receiving care and treatment in the community appeared to be different, and perhaps less prescriptive, to those found on the ward.

Also, of interest to me was that when a nurse moves from the hospital to the community the change happens not as an isolated experience, but takes place in a social setting and involves joining a group of other psychiatric nurses, working as CPNs, in a wider context. There is also an interactive network of further groups and agencies all of which can affect the experience. If the CPNs see their world of work as different to that of other psychiatric nurses and other caring professions in the community, as appeared to be the case from my earlier work, I wanted to understand the views of the CPNs about their work, their actions and perception of their therapeutic role in terms which they themselves use and understand. My aim was to make explicit the culture within which CPNs act by recording their stated views and by, interpreting these views, to understand any underlying shared values, the context in which the values are set and how they are related.

I was specifically interested in the "meaning" of the CPN's views, as the CPNs conceptualised them at the time of collecting the data. Therefore, I was looking for a theoretical perspective through which to structure the project to describe and interpret the set of values held by a group of professionals working in the NHS, which is a large and highly structured organisation. The methodological approach of Max Weber (Weber, 1930) coupled with his work on culture and bureaucracy appeared to be a useful starting point. The appeal of the work is that there is continuity between the method and the theory both of which depend on "verstehen" - an understanding of the organisation through the views and views of those who work in it rather than imposing a preconceived structure which may reflect an "outsider's" understanding.

There are other sociological theories of organisations (Huczynski & Buchanan 1991, Luthans, 1992, Reed 1992) but on the principle of Ockham's Razor (Lacey, 1993), of not elaborating beyond what is needed to explain a given set of data, it was decided to use a broad theoretical approach consistent with the exploratory nature of the proposed research. I was not initially concerned, for instance, with the details of power or status relationships between the various groups within the NHS unless they were seen or noted as important by the CPNs in their views. This is not to make any judgement about the importance of these issues, and many other aspects of the sociology of an organisation, but simply because many of the issues fell outside the scope of the research and would only become part of the project if they were present in the CPN culture.

The intention was also to avoid a theoretical approach which would force my thinking and analysis into an overly specific direction and yet to have a starting point from which to structure the research. Because Weber's work is concerned with the individual and social aspects of a large hierarchical organisation (Beetham, 1987) I felt, after considering other options, that Weber's theories were at a level of generality of explanation which was appropriate for my purposes. However, the research was not intended to test any hypothesis or predictions from the theory nor was it intended to test the theory as an explanation of organisational structure, discussed below. The intention was to use Weber's work as a framework from which to begin my exploration of the

CPN's social world. As the theory works with ideal types which do not necessarily describe any individual organisation exactly, it can be useful and productive by drawing a researcher's attention to areas if the real organisation differs from the "ideal" one (Beetham, 1987).

The research was based on two major concepts from Weber (Weber, 1968, Blau & Meyer, 1987, Beetham, 1987, Schroeder, 1992, Waters, 1994, Hughes et al, 1994). The first concept is that of "bureaucracy" analysing the way in which large organisations function, the second was the idea of "culture" which is defined as the set of values and ideas used by a group of people to describe, explain and plan their actions (Waters, 1994). Cultural values are not necessarily accurate, "right" or consistent in the sense of being logical or scientific causal explanations of the world in which the actors operate but are "theoretical" or "hypothetical" concepts which are used by the actors involved to describe and communicate their world view.

The anticipated value of Weber's ideas for the research was that he defined "bureaucracy" as an organisation which has a rational approach to its objectives with clearly and rationally defined roles both for those who manage internal workings of the organisation and for those whose work is the "product" of the organisation. *"Bureaucratic administration means fundamentally the exercise of control on the basis of knowledge. This is the feature which makes it specifically rational."* (Weber, 1968, p339) By extension from the ideas on culture, any group of people within a bureaucracy could be expected to have views, held in common and mutually understood, which not only reflect the "rules" of the organisation but which also concern areas where the rules conflict with the perceived reality of the world in which the group acts. *"... we shall speak of 'action' insofar as the individual attaches a subjective meaning to his (sic) behaviour ... action is 'social' insofar as its subjective meaning takes account of the behaviour of others ..."* (Weber, 1968, p4) .These ideas were seen as being of particular interest when considering the CPNs who initially trained as psychiatric nurses in a situation subject to a high degree of control from the organisation and then moved to work in a situation elsewhere in the structure where the work and organisational control are more loosely defined. (A specimen CMHT operational

policy is attached in Appendix 2 which is specific about administrative and managerial matters but does not include clinical issues.)

Methods of data collection and analysis were influenced by Weber's idea of culture and the way in which it contains the shared concepts and ideas used to communicate individual understanding of the social world in which the group acts. In this scheme, the discourse of a group with a common culture is seen as containing implicit and explicit expressions of view which derive from the values of the culture. The researcher's data are the *'already constituted meanings of active participants in the social world'* (Outhwaite, 1987, p. 68). In discourse, group members absorb, acquire and manipulate their views and through this communication the researcher can begin to understand the culture, by the process of *verstehen*, interpreting it using the terms and concepts found in discourse collected and recorded from group members. Then, by analysing the accumulated material, underlying values, explicit views and their relationships can be identified.

Weber: the concept of bureaucracy and the NHS as a bureaucracy.

In sociology the notion of bureaucracy, which derives originally from Weber's work, has been fundamental in studying formally constituted organisations in an industrial society (Beetham, 1987). The term originally referred to the administrative processes of government and other public bodies but has come to be extended to all organisations which have a formal structure and rules by which the activities of the organisation are managed. The growth of non-governmental organisations which can be seen as bureaucracies is intimately linked with the technological advances which allowed large scale industry to develop. Because the economic system is based on large scale capital investment, which requires a profit to be made for owners of capital and share holders, efficient operation of an organisation is a high priority and organisations have developed a bureaucratic structure to promote continuity of operation independently of particular individuals. The spread of bureaucracy into all large institutions since the 19th century can be seen as linked with the need to effectively and efficiently control the work of the employees of an organisation

in achieving the aims and objectives of the organisation. Secondly, the spread of bureaucracy is linked with the growth of science and technology which fostered the development of "rational" thinking by the leaders of organisations as opposed to "traditional" or "charismatic" appeals to authority (Hughes et al, 1995, Waters, 1994).

The theory of bureaucracy has been used as a framework by other organisation theorists after Weber (Beetham, 1987, Waters, 1994) to consider a variety of issues such as the efficiency of organisations, power and authority structures within organisations, the processes of change in organisations and how bureaucracies wield power in the state.

One consequence of the growth of bureaucracy has been for it to become an end in itself, for some individuals employed by the organisation, in terms of gaining personal power and authority, rather than a means for providing a "product" (Hughes et al 1995). This idea suggests there is the potential for a person or a group within an organisation to develop power and influence by becoming skilled at using the "rules" of the organisation. A group of people with similar power acting jointly, perhaps to achieve additional influence within the organisation at times of change, can be seen as having a sub-culture in the sense that some of their views are particular to them rather than the wider organisation and their operation of the "rules" could be influenced by their group views. This possibility may begin to explain how the medical profession has maintained dominance over other professions and occupations in health care services. Another way of achieving power, in organisations where the emphasis is on technical skill and education (particularly if the right to practice is defined by law as it is with medicine) is for the group with those characteristics to have an advantage in claiming power on the grounds that they are contributing most to achieving the objectives of the organisation.

The characteristics of a bureaucracy of interest to this research (Weber, 1968, Blau & Meyer, 1987, Beetham, 1987, Schroeder, 1992, Waters, 1994, Hughes et al, 1994) are that there is a stated objective for the organisation's activities, and the roles, duties, responsibilities and accountability of its employees ("officers"

in Weber) are, or should be, clearly and explicitly stated. The basis for all activity is what Weber called "legal-rational" behaviour, that is actions having a logical, objective and impersonal basis: this applies to the relationships of the officers with the organisation as well as with those whom the organisation serves - the customers or clients. Because of the emphasis placed on following a set of rules a bureaucracy tends to be resistant to change in these "rules and regulations" which govern the work and authority/power relationships of all of its members.

Whilst the NHS is a larger and more complex organisation than those which Weber used to derive his theory, the essential components of his characterisation are still present:

- a specific sphere of competence,
- a high degree of specialisation,
- a hierarchical structure with clearly defined divisions of labour,
- defined, rational and documented rules for the workings of the service,
- impersonal relationships between the organisation's members and clients,
- the recruitment of personnel on the basis of ability and technical knowledge,
- job requirements are assessed and salary is paid on a defined scale for that assessment,
- promotion is on the basis of experience and merit,
- actions and outcomes are documented and filed.

(Abercrombie et al, 1994, Waters, 1994).

In these terms the NHS can be seen as a bureaucracy, or perhaps more accurately as a series of parallel bureaucracies, all with different detailed objectives within the broad objective of the whole organisation (Beetham, 1987). One possible distinction between the different component structures is the clinical versus non-clinical tasks which the NHS undertakes but within these there are finer distinctions such as administration, activity monitoring and finance within the non-clinical areas and on the other hand between medicine, nursing and other clinical disciplines in the clinical areas. There is also the consequences for the organisational structure and rules imposed by the requirements of external regulatory bodies such as the General Medical Council

and the Royal Colleges for doctors, the UKCC and the Royal College of Nursing for nurses as well as the professional bodies for all other disciplines involved in providing health care. A further complication is that the organisation is structured at several levels, national, regional and local, with their own relatively self contained structure nested within the larger structure on a descending scale of size.

One of the criticisms of Weber's definition of a bureaucracy is that it does not allow for the significance of external agencies, such as the GMC, UKCC and other bodies which provide professional accreditation to health care workers. Therefore, professionals can be seen as accountable to more than one bureaucracy (Beetham 1987, Blau & Meyer, 1987). In this, the NHS departs from the "ideal" bureaucracy in that there are two major types of authority governing the work of many of its "officers" - the NHS bureaucracy itself, as the employer, and external bodies governing the technical performance of workers. A second major difference between professionals and administrative staff in the bureaucracy is the level of training. At the time the concept of a bureaucracy was developed, administrators learnt their jobs from others in the organisation: known colloquially as "sitting by Nelly" learning. In contrast, professionals undertake more education and are required to pass rigorous examinations before being granted the right to practice. A characteristic of a professional is that, having being passed as fit to practice, they have autonomy of action based on their established expertise.

It is argued that this difference between administrators and professionals has blurred in a modern organisation. There is increasing sophistication in the tasks undertaken by the "administration" which are beginning to need the same level of technical expertise and training as the "professionals" (Waters,1994). Training for other groups is validated and accredited by external bodies who grant a range of approved levels of qualification in areas such as finance, engineering, catering, office work and general management. In some of these areas such as finance and engineering the professional can achieve "chartered" status which means they have achieved a high level of expertise defined by a body which is licensed by statute law to grant such status as for nurses and doctors.

In medicine and nursing, there is also the parallel growth of "bureaucratisation" in the clinical practice of nursing and medicine (Gray & Jenkins, 1999). This is happening in two ways: the professionals are becoming more accountable to the NHS management as well as to validating and regulating professional bodies and, secondly, there is an increasing standardisation and formalisation of clinical practice in terms of protocols which define the "ideal" treatment and the promotion of "good practice" in order to ensure and manage the quality of practice. At the time of the research, initiatives such as the Community Programme Approach (DoH, 1990), where a named professional had specific and recorded duties in managing the delivery and quality of care, were adding more formal rules and requirements to the management of clinical practice and patient care.

Gray and Jenkins (1999) argue that since 1974 there has been an increasing emphasis on the financial aspects of health care delivery which has allowed non-clinical managers to influence clinical work by linking costs, service content and service volume with the result that there has been a growth of accountability to managers for clinicians. A second influence, active during my fieldwork, was the creation of Trusts and GP fund holding in the early 1990s, where authority was devolved from a centralised structure of Regions, Districts and Units to NHS Trusts which were more autonomous than the Units from which they evolved. These changes in structure were accompanied, and regulated by, increases in formal contractual agreements which specified service content and conditions for its delivery in a way which increased, and made explicit, the accountability of clinical staff in the organisational "rules".

This suggests that, in the case of the NHS, the presence of a large numbers of professionals in both administrative and clinical areas does not undermine the notion that it can be regarded as bureaucratic, even if there is not a single "straight through" chain of command. The grounds for the argument are that the NHS is the employer of the nursing and medical professionals and that while their clinical competence can only be judged by their peers the organisation requires, as an integral part of its rules, that its professionals work to the

competence specified by external organisations. Possessing the appropriate qualifications is a defined specification for employment with the NHS. Once employed, if a medical, or other, professional falls short of the standards set by the validating body, the administration then terminates their employment for breaking the rules. This applies equally to doctors, nurses and accountants. Further, there are internal bodies such as audit departments, attached to the NHS which are charged with checking that the rules are being properly observed in the same way as clinical practice is accredited and audited. In addition, the so-called clinical autonomy of the individual to practice according to their judgement is being challenged by the introduction of specific defined protocols and procedures for treatment of many conditions (Bean, 1985).

A second issue in the critique of Weber's theory, is that no bureaucracy is found in its "pure" or "ideal" form in that its employees or "officers" do not always act precisely according to the rational and impersonal rules and objectives of the organisation (Beetham, 1987). Another issue is the extent to which the goals and objectives can be realised in practice through the activities of individuals, especially professionals working directly with service users (Lipsky, 1980). Each person brings their own agenda to the work and whilst people are socialised into behaving in organisationally-approved ways they all interpret and apply the rules with some degree of difference from each other. If it can be said that the outside world leaks into a bureaucracy there is also a leakage in the opposite direction where the position a person holds in a bureaucracy confers differing degree of status, or lack of it, in the person's social world outside of the organisation. This interaction between the bureaucracy and the wider world in which it is situated will have consequences for the way people have personal views derived from cultural values because they will not simply be expressing the "party line" but adding, in varying degrees, to the official version their own experiences both inside and outside the organisation.

The working of such a large complex organisation is a research topic in its own right but for the present research the significance of the bureaucratic structure of the NHS is that, at the point where services are delivered, such as for a group of CPNs working at the local level of the organisation, there will be a variety of

"rules" and organisational demands which can originate at any level in the NHS from national to local, as well as from external sources. However, there is an anomaly in that whilst the CPNs' salary, travel expenses and conditions of employment generally are all subject to documented rules, the clinical content of their practice is not subject to written rules. (See appendix 2 for a typical CMHT policy document.) Instead there was, at the time of fieldwork in South Durham, a set of unwritten, but verbally explicit "procedures" and "protocols", defined as good practice, by nurses and their professional body, which depend on clinical judgement - a mixture of formal data from assessment procedures coupled with experience of other similar cases and, to some extent, intuition. The lack of a formal written definition of the CPNs' work is a departure from the "ideal" bureaucracy. This may be reflected in the CPNs' views in terms of ways in which they believe they can, or have to, justify and legitimise their actions and decisions.

Formal rules, however, do apply to the recording of clinical activity: all assessments, care/treatment offered are recorded in the patient/client's case notes along with a variety of other pertinent information about the patient/client. There is a national code of practice governing the writing of nursing case notes which may not have the standing of law but which, if ignored or not followed, may involve disciplinary action against a CPN. Hence the departure from the "ideal" in the lack of documented procedures, referred to in the paragraph above, may have very real and unpleasant consequences for an individual CPN if something goes wrong or there is a complaint from a client or doctor about the CPN's conduct and/or judgement. There are limits to the "looseness" of managerial control: team leaders regularly reviewed the progress of all cases, on an individual one-by-one basis, with each of their CPNs and although no formal quality measures were used, a subjective judgement of the progress or outcome of each case were made.

The NHS as an organisation is large and its overall objective is to maximise the health of the people it serves by treating problems which occur and by promoting healthy living styles which minimise the risk of becoming ill. (The NHS Plan,1998) Within this broad description the NHS is differentiated into a

multiplicity of different occupations with particular skills who work in specific areas of care. This suggests that there will be many sub-cultures (Clark et al, in Hall and Jefferson, 1976) which will hold values drawn from the overall culture of the organisation, the local "official" rules for the particular group and other views drawn from using the "rules" in their day to day activity.

The South Durham CPNs work in a small part of a large organisation with a complex structure, based on observation and questioning during my day-to-day work with them, and appear to have a well defined, if partly unwritten, common understanding of what they are doing for their clients. This suggests that they will have a shared set of views, about what a CPN "is", which will constitute a culture. The characteristics of a "culture" will now be examined in more detail.

Weber and Culture.

The second idea drawn from Weber's work is that of culture: the totality of ideas, knowledge and experience of an actor's social world which is shared with other actors. A culture, according to Weber, is a set of common understandings of a particular social setting shared by a group of people, which functions as a conceptual framework for communication, explanation of past actions and planning future actions – culture is how actors explain their actions to themselves and others (Weber, 1947,1968,Clark et al, 1976, Alexander & Seidman, 1990). Weber was concerned with the effect of group action and culture is seen as the means by which actors integrate their actions within the group. He also stated that "the acting individual attaches a subjective meaning to his (sic) behaviour" and that action is "social" in as far as it its subjective meaning takes into account the behaviour of others.

He developed a typology of basic reasons for acting :

- traditional social action – habitual and customary, largely unquestioned
- affectual social action – expressing emotions and feelings

- instrumentally rational action – logical, goal directed action for a discernable purpose
- value rational action – "determined by a conscious belief in the value of some ... form of behaviour, independently of its prospects of success".

(discussed in Hughes *et al*, 1995)

The terms "value rational" and "instrumentally rational" are not used quite as they are today. The distinction is that Weber saw "instrumentally rational" actions as such straightforward things as putting up an umbrella to cover one's head because it is raining. "Value rational" behaviour is more complex in that it involves a belief that one is acting for a purpose which may not have such an immediate result. Instrumentally rational behaviour also involves a belief e.g. that the umbrella will act to shield the rain effectively but there is a difference between this simple connection and the beliefs involved in value rational behaviour where the reasons for acting may be much more abstract.

Value rational action is seen as central to the early development of a bureaucracy because in a large scale capitalist society there is a need for stable, extensive and binding administration which depends on this type of behaviour. As the bureaucracy develops and becomes an established and central feature of large organisations, instrumentally rational action becomes dominant (Hughes et al, 1995, Waters, 1994).Those employed by a bureaucracy are seen as accepting the need for the organisation to exist and to have "rules" for it to be able to function. Weber identified the increasingly rationalisation of modern society, especially where education and work are concerned. Post-Weberian thinking suggests that there are three unifying themes in Weber's work which apply to modern life – knowledge and acting rationally based on that knowledge, impersonality in the application of the "rules" of bureaucratised society and the dominance of instrumental needs of large organisations over the needs of the individual (Waters, 1994).

However, if bureaucracy is as widespread and binding as Weber expected it to be, society would be caught in an "iron cage" of rules which would stifle change and force new ideas into the mould of the existing situation. Similarly, if a

bureaucracy is seen as an organisation with prescribed "rules" and procedures based on rationality there is a question about how the organisation responds to technological and social change. In many ways, this situation has parallels with the notion of a "paradigm" (Kuhn, 1970) in which "intellectual" bureaucracy constitutes a paradigm for the organisation of knowledge and where all new ideas and research findings are interpreted by reference to the existing, tested and accepted set of ideas which constitute the "paradigm". Ideas which initially contradict the received wisdom of the paradigm are rejected or disbelieved and will not be allowed as a challenge to the existing set of ideas until it is firmly demonstrated that the contradictions cannot be refuted or explained away - at this point the new paradigm can replace the previous one. Both old and new paradigms may exist side by side for some time until the newer paradigm is fully accepted.

Weber suggested that there are only a few particular individuals who are crucial both to generating change in a culture and to the acceptance of the changes by others - he called those individuals "switchmen", using a metaphor from the early railways where the "switch men" operated the points on a railway (Weber, 1968). Change can come from the top of an organisation, created by those having the authority to make change but can also arise amongst those lower down in the organisation where the difference between the "ideal" operation of the rules and the application of those rules in the "real" world are seen and created, becoming part of the culture (Lipsky, 1980).

Cultural values are not necessarily understood consistently within or between individuals. Weber argued that cultural values when combined with an individual's life experiences, are expressed at the level of an individual actor as "views" which will vary between actors. For instance, there is an explicit value that community care is an important issue for people with severe and enduring mental health problems. This general value will form an individual view, for a particular CPN, when it is merged with their personal experience and opinions. Similarly, there may be contradictions between the many views held by a single individual – there is no requirement for logical consistency in a person's views.

Taken together these theories suggest that the overall culture of a group of people will represent the group's values and rules which act to regulate relationships and actions within the group, especially how power and control are exercised. However, there will be variations between individuals in the way they understand and interpret the views. The NHS can be seen as a bureaucracy, or series of interlocked parallel bureaucracies, in which both the rationale of the organisation and the development of the substantive content of the "product" – health care – are based on rationality and value rational behaviour.

Therefore, I anticipated that the culture of a group of people working in such a complex bureaucracy, especially at a time of change, will express not only the "official" view of the rules but also contradictions and anomalous views, drawn from experience, which are not part of "official" policy and which have not yet become strong enough to constitute a serious challenge to the rules.

Ontological and epistemological continuity in Weber's theory.

One of the attractions in using Weber's ideas as a starting point for my work is that the research can be then seen as having ontological, epistemological and methodological continuity. The way in which a values and ideas function in a culture, or sub-culture, and are used in thought and speech to understand the group's actions, and to express that understanding between members of the group, is also a means of collecting information for research on the culture. Such consistency is important when considering the reliability of the research (Mason, 1996, Silverman, 1993). The use of an established theoretical stance does not in itself offer automatic exemption from criticism because there are caveats and critiques about all theoretical thinking (Popper, 1945 in Miller, 1953, Mason, 1996, Silverman,, 1994, Smith, 1975, Coffey & Atkinson, 1996, Phelan & Reynolds, 1996). However, I felt that starting with a known theory and methods would be a productive means of organising the work, providing that there was clear exposition of the assumptions made and of the reasoning used to achieve the results.

Of particular interest is that, ontologically, in Weber's analysis of individuals it is their ideas and thoughts which constitute "society": there are no externally imposed influences from any abstract entities such as "society". People create "society" as a label to describe and express their experiences of living in a group. Therefore, any explanation of human behaviour which does not include the actors' own understanding of the social world is not a complete or accurate representation of human experience (Hughes et al, 1995).

Also, epistemologically, the understandings of people's social world are expressed in individual views which are used to communicate about the world, to explain past and current actions and to plan future actions. There is no requirement that these views are accurate in the sense they reflect a correct causal explanation for events. All that is required to define a culture is that the values are shared by members of a particular group, and the values are reflected in their individual views. "Culture" groups can be on a large or small scale although larger culture groups tend to contain smaller sub cultures.(Haviland, 1999). Cultural values and ideas are not always explicit in thought and speech, indeed they may be implicit and relatively unarticulated, lying hidden underneath discourse as assumptions.

Also, cultural values and issues are not always consistently understood by each actor but may be expressed at one remove as "views" in which the individuals' own unique experiences may lead to them having opposing or differing views about a particular issue but there is an shared understanding that the issue is important. For example, if CPNs are divided about care in the community one may find a range of personal views about the extent to which people with a mental illness should be treated in the community, in the light of how dangerous their condition makes them, or whether they should be cared for in hospital. These "opinions" are informed by values interacting with personal experience but one would expect to find an underlying value that care in the community is an important and valid issue for the CPN. For the researcher, discourse is a visible and collectable source of data which can be used to define and understand the culture of a group of people.

How the concepts of bureaucracy and culture helped to frame the research.

The main value of the ideas discussed above is that they enabled me generally to begin to understand the workings of a large and complex organisation and how a particular occupational group may relate to, and function within, the larger organisation. Secondly, the work allowed me to focus on the way the CPNs could understand and communicate about their activities. Given the complexity of the organisation and the nature of culture a key question began to develop about the relationship between the culture of the CPNs and that of other parts of the organisation. This is an important issue because if CPNs' view of their world is not shared by the managers and service planners in the organisation, for instance, there is a potential for misunderstandings about the CPN role, aims, goals and practice to the potential detriment of developing better services and care for people with mental health problems.

During the two decades or so before starting this research the NHS has undergone a series of structural changes generally as well as some large scale changes specific to the delivery of mental health services. This raised the question of what effect the changes have had on the organisation's culture - and whether a particular change is seen as positive or negative. Resistance to change can be created if the organisation does not have "rules" and policies about how change will be handled or if the "rules" have the purpose of resisting change (Clark et al, 1976, Gagliardi 1986, Robbins, 1984). It could be expected that the culture of people working in a changing organisation would reflect both the degree to which the organisation was prepared for the effects of change and about the group's role in promoting or resisting change. This would be particularly of interest when the policy to make changes is not generated entirely internally by those running the organisation, in response to such things as "market forces". For the NHS there are many sources of pressure for change: Government decisions based on political and ideological priorities as well the progress of medical technology, new pharmaceutical products, the Government's ability to fund new products and procedures as they develop. For my research, the main area of interest was the long term changes in mental health care culminating in the run-down of large old mental hospitals in favour of acute

psychiatry based in a general hospital or care in the community which serve a variety of patient groups from those with acute short term problems to those with intractable chronic mental disorders (Tomlinson, 1991).

Therefore, according the above theories, it appeared that the South Durham CPNs, as a specific occupational group working together could be expected to have a culture which would be reflected in a coherent set of views about their role, and their relationship with other occupational groups, their clients and with the larger organisation in which they are situated.

Method

This section is a discussion of the methodology used, the generation of the topics for interviews and selection of the sample group followed by an account of entering the field, data collection and data analysis. A discussion of the issues of reliability and validity of the method will complete the chapter.

I was specifically interested in the "meaning" of the CPNs' culture as the CPNs themselves understood it, mainly because my prior work with these nurses suggested that they thought that their role and work were not understood or appreciated by other mental health workers. I felt that this called for a method which would allow me to make statements about how the CPNs' understand, experience and reproduce the complex and multi-layered social world of their work (Mason, 1996). The aim was to make explicit the culture in which CPNs act by recording their stated views about their actions and, by interpreting these views, to search for any underlying shared values, define the context in which culture is set and how the values and views are related. Sociology has a long tradition of using a variety of qualitative research designs to produce such "rich, contextual and detailed" descriptions in which the research should be, and can be, "systematically and rigorously conducted" (Mason, 1996).

Qualitative research - strengths, weaknesses, validity and reliability

Qualitative research is not a single standardised method - there are many different approaches, as there are in quantitative research. The distinction between qualitative and quantitative work is to some extent artificial as they can be seen as a continuum, and some work will use both methods. The identification of quantitative methods with a positivist epistemology and qualitative methods with a more holistic post-positivist approach is also arbitrary, serving to generate a dichotomy of method which does not really exist. (Coffey & Atkinson, 1996, Smith, 1975). In research design the criteria for the choice of a particular method, ideally, are what type of information is sought and the purpose for which the findings are to be used (Bryman & Cramer, 1995).

A qualitative approach can be seen as having strengths when the research is intended to elucidate the "meaning" of a social situation for the actors concerned (Silverman, 1993). Qualitative research "*aims to produce rounded understandings on the basis of rich, contextual and detailed data*" (Mason 1996, p4). Generally, "pure" quantitative research draws hypotheses from a theory and tests it by collecting data, by counting or measuring through accepted operational variables, before performing statistical analyses to test the probability that the hypothesis can be accepted or not. However, both methods can be used in a research project – for example, theories can be developed using qualitative "grounded" methods and then quantitative methods used to test hypotheses about relationships. Broadly quantitative research is concerned with causality and measuring correlation whereas qualitative work aims to explore "meaning" and context. Therefore, as I was concerned with the understanding the "meanings" of the CPN culture a qualitative approach is indicated.

There are criticisms about perceived weaknesses of qualitative work in that when the researcher is not proceeding from a known and tested theoretical base, but is "interpreting" the data according to the researcher's understanding, there is the possibility that the findings are only a well informed opinion. Qualitative research data are often collected in a naturalistic setting which is not "controlled" in the sense that a quantitative researcher would be regard as necessary. Also, the

researcher, by being active in the research setting, is an influence which is potentially distorting to the situation under scrutiny. This is also an issue in quantitative work as well but is controlled for in different ways, such as "double blind" trials and the use of control and experimental settings. There are various stratagems employed by qualitative researchers to avoid threats to the validity of the work in order to provide the desired "rich picture" of their chosen research setting (Coffey &Atkinson, 1996).

The key elements which all qualitative work needs to address are that the work should be rigorously and systematically conducted whilst being flexible and sensitive to the context. There is a need for researchers to be aware of the assumptions they are making and take stock of their actions and role in the research process - reflexivity. The final presentation of the findings should make explicit all of these elements in order to produce a convincing explanation of the setting under investigation (Mason, 1996).

The definition of the terms "validity" and "reliability", in the literature, vary between authors. For my purposes validity is taken to mean the appropriateness of the interview for collecting information which represents the workings of a social setting under study. This is why Weber's work was used because there is an ontological-epistemological-methodological continuity in the theory. Reliability is taken to mean the replicability of the interpretation of the data - would others working with the same data come to the same conclusions? (Mason, 1996, Silverman, 1994, Bickman & Rog, 1998).

Undertaking qualitative research raises particular issues of validity for the final findings when the work is undertaken in the field using a semi-structured method. A description of the CPN culture, as the CPNs themselves experience and express it, was the initial objective of the work but there is the danger that the researcher's pre-existing knowledge and views can be imposed on the data, thus distorting the interpretation. There is also the risk of producing interpretations which go beyond the point to which the data support the interpretation. The issue of validity of the interview as my data collection method, and reliability of the analysis, were considered before beginning field

work in an effort to minimise any bias in data collection which could arise from my prior assumptions in both method and interview topics.

It was a basic assumption that collecting purely "objective" information is not possible, nor in this particular piece of work was it desirable because the purpose of the study was to understand the CPNs' social world through their own views about it. The key question when considering validity was how well the CPNs' views can be recorded and explored using an interview technique. (Mason, 1996) The literature discussing the open or unstructured interview (Silverman, 1994, Bickman & Rog, 1998) made me aware that the eventual analysis would have limitations based on the notion that all interviews are negotiated situations and that any information revealed could not be claimed to be complete or "unslanted". However, because I was beginning the work from a Weberian approach this included the assumption that a semi-structured interview can be seen as a social interaction, based on common understandings, and which, like other social situations is not open and unbiased but subject to all kinds of manipulation and self-censorship. The process of "*verstehen*", used systematically, can be used expose any underlying bias or slant of views by comparing the individual responses and looking for anomalous or conflicting views being expressed.

I could not do the work by merely mechanically recording statements made by CPNs at interview but had also to undertake a thorough and careful analysis of the information without adding to or over-extending what was being said. The initial task was therefore to collect information in a systematic and rigorous way without becoming rigid and over structured although, inevitably, my eventual interpretation of the data was only one of many possible ones, all of which could be legitimate interpretations depending on what information was being sought from the interview material.

Another threat to validity was that because I only had a single stage of data collection, with limited opportunities to check and expand on the collected information, I felt the interpretation would lack some conviction because it had not been discussed with the original interviewees. This was treated in several

ways. Firstly, at the interview stage each interviewee would be offered the opportunity to add material to supplement their earlier answers or to raise new topics which were relevant. Secondly, each interviewee was given a transcript of their interview and invited again to add material to supplement their earlier answers or to raise new topics which they felt were relevant. It was intended to ask a third party to consider the transcript material and compare their observations with mine, however it proved difficult to find a colleague with sufficient time to read and interpret a substantial part of the data. Therefore, the themes and the material on which they were based were discussed in three meetings with two senior nurses who had both been CPNs, until recently, but had left the field before I began data collection. Finally, limitations of completeness in the analysis would have to be accepted and noted at the time of presenting the findings, particularly the lack of opportunity to ensure that the themes I had found were "saturated" by returning to the field and collecting further material.

"Verstehen" as method

The distinction, discussed earlier, about cultural values and individual views leads to a consideration of the method associated with Weber's work. Values are found in the discourse of the individual: they arise from a combination of individual experience and cultural values. Simply analysing discourse and describing the values found is of interest in knowing what a particular group of people think and are concerned about but without further analysis, designed to make explicit the underlying structure and how the values are related, would say little about the culture of the actors (Mason, 1996, Silverman, 1994, Smith, 1975, Coffey & Atkinson, 1996).

Weber (1968) was insistent that values are not directly observable but that by "*verstehen*" or "interpretation", (the German actually means "understanding" and "comprehension" Sasse, 1966) views expressed in observable discourse - using everyday speech and expression as the raw data - can be analysed and described in a rigorous way both to uncover cultural values and to explore possible relationships between them. In this way, the culture is made explicit but in terms that have meaning and significance for the actors concerned, not according to a

schema imposed on the data from external sources. Interpretation is seen by Weber both as the naturally occurring social mechanism by which understanding is mediated by members of a group and as a method of analysis which when formally and systematically used can produce reliable results providing the steps of reasoning, from data to articulated values, are made explicit.

Ideally, using Weber as a model for the work, the data for the research could have been collected by a long period of observing, and recording, the day to day conversation of the CPNs. Given the time available, it was decided modify the approach and to use a semi-structured interview with the topics for interview pre-selected from a previous work, frequent contact with the CPNs and the literature.

It has been argued that an interview is not proxy for everyday discourse (Mason, 1996, Silverman 1993, Coffey and Atkinson 1996) in that it is an artificial situation which can produce bias in the information given, or revealed, precisely because it is "constructed" and not necessarily the same as day to day interactions found in the "real" world. However, there are several points to be made about this issue. All interactions are to some extent "constructed" and therefore everyday discourse is not a unique event with a claim to particular truth. It is questionable whether people, as social actors, ever produce completely honest and open discourse in any situation.

However, there is a threat to the validity and reliability of the work in the extent of people's willingness to be open, or to produce partial or distorted accounts, in a "strange" situation - the researcher needs to be aware of the possibility and being mindful of it during analysis. This awareness will not in itself remove bias or the incompleteness of an account but can alert the interviewer to the need both to note the possibility of bias etc, and to rephrase questions or ask further questions for clarification. Noting that an account may be incomplete allows the data to be qualified when interpreting it. For example, if one person expresses a view which differs radically from the majority, and the interview notes suggest an inferred bias in answering during the interview, any interpretation of the meaning of that view can be qualified by the dissent. The whole point of

"verstehen" is that cultural values have to be inferred from views expressed in everyday discourse - cultural values are not necessarily explicit in that discourse.

A completely unstructured approach would have been ideal, in spite of my already broad understanding and familiarity with the CPN and their work acquired as part of my work as a senior manager in the NHS. My existing understanding could have been challenged by using an unstructured approach which would have allowed interviewees to introduce topics and issues without any prompting, but would have been time consuming, perhaps needing several interviews to fully explore the issues. However, there were two constraints on the time available for data collection. My time for collecting data was limited by the need to meet academic deadlines and, as the CPNs were being interviewed during working hours, which was taking them away from their clinical work, one of the conditions imposed on me was to limit the length of interviews as much as possible. A second option would have been to use a fully structured approach but, as the work was predicated on the assumption that the CPN culture is not yet well defined in the literature, this approach would have been contradictory to the exploratory nature of the work. Therefore, to maintain as much openness and flexibility in the data collection, whilst being aware of the limited time available, it was decided that the best compromise was to use a semi-structured approach. This approach was intended to maximise the amount of material that could be collected in the fieldwork for use in subsequent analysis. My existing understanding could still be challenged by explicitly checking my views with interviewees during the fieldwork which would lead to a reflexive account in the analysis.

There are also two points specific to the particular research situation: CPNs are familiar with interview type situations when talking to clients: a clinical assessment is a form of interview although in the fieldwork the roles were reversed and the CPN was the interviewer and not the interviewee. Also, many of the CPNs were not strangers but were accustomed to seeing me in their working environment and were already used to my asking questions about their clinical work. By being aware of this contact, I hoped to maximise the CPNs' willingness to be open, by building on existing trust when interviewing CPNs

who did not know me so well. The possibility of individual bias in both my everyday work and the fieldwork would exist but would hopefully become apparent during analysis unless all interviewees gave me the same "party line".

Themes for the interviews.

The procedure used to generate the interview topics was to utilise knowledge of the CPNs themselves from a previous research project as well as contact with them through my work with the Trust, knowledge of the changes that were taking place in the NHS, nationally and locally, and the literature. As mentioned previously, in an ideal piece of research this is the material that would be collected gradually by observing the CPNs' daily interactions and discourse - although to some extent this knowledge had accumulated for other reasons before the research commenced. Because of the time and resource constraints it was decided to take this course on the assumption that the issues known from the literature and my existing awareness would be relevant to the CPN culture. Secondly, by using a semi-structured interview with broad topics, and encouragement for respondents to engage in relatively free discussion, there would be the opportunity to note new issues which could then be explored in subsequent interviews.

There were additional reasons for deciding to use foreshadowed themes. Because my work with the NHS involved amongst other things carrying out management research in the clinical arena, I was already in a position somewhere between being an external observer and being a participant observer. Although I was not an "insider" for the group of CPNs, I was also not an "outsider" for many of them and they talked to me with the assumption that I understood their social and clinical world because we had previously collaborated on several projects and in-depth reviews of their work. Therefore I was not a naive researcher, but already had knowledge of, and contact with, the CPNs' ideas and values and it would have been unrealistic to try to ignore my existing experience. I felt that there was a bigger risk to reliability by pretending to be a naive observer because existing knowledge could not be prevented from leaking into the work. It was judged more appropriate to recognise existing knowledge and to use it consciously in a

formal and objective way which would make explicit the contribution. Instead of trying to eliminate prior awareness as a potential source of bias the goal was to use the existing awareness to increase my understanding during collection and analysis of the data. (Bickman and Rog, 1998).

The first stage in formulating the topics for interview was to consult the sociological and nursing literature to note the broad concepts used by nurses to describe and discuss the issues in their work. Both general and CPN literature were used because whilst CPNs are specialist nurses working in the community or with patients in the community they share some concerns with colleagues in other areas of nursing. From my day to day work, I knew that some of the CPNs were "double" trained: either they held both general and psychiatric Registration or had "mental handicap" (sic: as Registered Mental Handicap Nurses) and psychiatric Registration. Some double-trained staff had come initially from general nursing to psychiatry but others had done their general training after qualifying as a psychiatric nurse. Therefore a "leakage" of values between the various branches of nursing and their particular cultures had to be anticipated.

The second stage was to use the knowledge of the South Durham CPNs which I already had from my work with them and add this to the material from the literature. Issues were put into broad categories, to avoid having a very long list of specific issues which could constrain the interview. By using broad questions I hoped to allow the opportunity for the introduction of issues possibly not covered by the interview topics.

The interview topics were designed to begin with an exploration of the CPNs' views on aspects of their experience from the beginning of their career, covering training and earlier experience in hospital, training (informal or formal) then moving on to broad questions about experience and the nature of their work in the community. Issues introduced by the respondent were encouraged and discussed in as much detail as time allowed. A blank interview schedule is appended (Appendix 3)

Before beginning the main data collection with the CPNs, the interview topics were used in two pilot interviews with staff who had previously been CPNs but who were now working in another specialist service in a similar role to the CPNs. Following the pilot interviews, one question about "rules" was dropped because what was being asked was not immediately comprehensible to the interviewees. The pilot interviews were approximately one hour long and after measuring the time it took to do a transcription it was decided to try and cover all the topics in approximately 45 minutes with 15 minutes available for additional material.

The sample of CPNs for interview.

The first problem to be solved in deciding who to include in the study was the question "what is a CPN?" At the time of my field work there was no common national definition as to the training, qualification or clinical practice of "a CPN" (Brooker & White, 1991, Ross et al, 1998) - this lack of definition is still the case in 2002. Therefore, in line with the theoretical perspective of the work it was decided to ask the CPNs themselves for a definition. The community psychiatric nursing teams working for the South Durham Community Trust had nurses of several grades supported by care assistants. The person who had originally set up and managed the CPNs in the South West Durham Mental Health Unit, was consulted about the criteria which define a CPN and their work. Ideally, it was felt that the title of CPN should be reserved for those who had undertaken the post Registration one year CPN Certificate. However, as this is not mandatory, a psychiatric nurse can work in the community without the Certificate unlike other community nurses, such as midwives, district nurses and health visitors. The major distinction he noted was that, immediately after a referral is made, all clients are initially assessed by a G grade community psychiatric nurse who also develops a care plan with the client. The implementation of the care plan can be delegated to psychiatric nurses of lower grades depending on the complexity, severity and risk inherent in the client's problem. This distinction was thought to be significant because the G grade has a level of autonomy and responsibility not shared by other grades of psychiatric nurse in the community.

The usefulness of qualification to define a "CPN" was also discussed with CPN team leaders who agreed that it was not satisfactory because not all the most senior grade nurses and team leaders had the specific CPN qualification. The team leaders agreed that another definition of a CPN had to be sought and differences of clinical responsibility significant. When asked the question "who is a CPN" the team leaders agreed that the G grade nurses should be considered as the "real CPN" because, after assessment, all referrals remained the responsibility of the G grade nurse and remained on their case-load until discharge, even when care was provided by the lower grades of nurse. This definition was therefore used because it was based on a view held by CPNs and was consistent with the theoretical perspective of the research.

Using the above definition there were 35 people in the South Durham service who could be considered as potential interviewees for my sample. The next consideration was the time available to interview them, discussed above, which was limited. Given these limits, there appeared to be two possible sampling strategies, the first was to sample 50%, either by team or individual, of the CPNs and conduct two interviews. The initial interview would be used to elicit a broad picture of CPNs' views followed by a preliminary analysis of the data which would feed back into the topics for a second, in-depth, interview to seek more detail. This would also allow me to approach other CPNs, not initially chosen, in case of refusal to be interviewed by any of those first approached.

The second sampling strategy was to conduct a single interview with as many as possible of the available CPNs which would maximise my coverage of the possible range of individual values particularly for values held by a minority amongst the group. The increase in coverage would have to be at the expense of any exploration of the material in-depth because there would not be sufficient time to conduct second interviews.

After consideration the second strategy was finally chosen, for several reasons. The first was because the research was exploring a range of values, rather than testing a specific hypothesis drawn from previous work, maximum possible coverage was deemed advisable. In the second place, there was no way of

knowing whether second interviews would add any detail to the initial work. A further consideration was that a 50% sample would only represent 17-18 people drawn from two geographical areas which until shortly before the research had been separate entities.

Entry to the field.

The Director responsible for operational activity, who had initially supported my request to do the research, gave me permission in writing to approach the CPNs and to allow them to undertake interviews in NHS time. Approval was conditional on the observation of several conditions, which were also approved by the South West Durham Health Authority Ethics Committee.

The conditions under which permission was granted for the research to be carried out were:

- the research should be separate from my other research work done for the NHS in terms of use of my time and resources;

- all information given to me was to be kept confidential and that I should be the only person to see it: nothing revealed to me was to be communicated to the Trust's managers in a way which would identify the interviewee;

- any information quoted when writing my thesis should be used anonymously;

- all CPNs should be free to refuse to participate and no pressure should be used, particularly by using my senior management status.

The only possibility that these conditions would be problematic was if I was given evidence by a CPN of dangerous or negligent practice by themselves or another- there would then be a conflict of interest. This possibility was discussed with the head of the ethics committee, the Director responsible for the CPNs' work and a member of the University staff and although no formally defined procedure was agreed it was agreed that we would discuss it further if such a

conflict occurred. In the event this was not a problem as there were no revelations which fell into this category.

Under these conditions, each CPN team leader was approached in turn and asked to invite me to one of the monthly team meetings where all the CPNs I wished to interview would be present. The team leader was given a detailed summary of my research intentions, the conditions under which I was allowed to work, methods and that I wanted to ask for volunteer subjects for interview. All of the team leaders were supportive and spontaneously expressed interest and enthusiasm for the ideas.

Having gained the team leader's support, a short verbal presentation was made to the teams as part of their monthly team meetings. The research intentions and basic conditions were explained, with the addition of some more detailed safeguards I proposed to use:

- interviews would be taped, with the agreement of the interviewee
- the tapes would be supplemented by detailed written notes
- interviews would take place in a private room where no one else could overhear the interview
- all tapes and notes would be held in my home and would never be taken to my place of work
- all tapes would only be heard by the interviewee and myself if they wished to have a copy
- all tapes would have no other label but a two-letter code and the list relating names to codes would be held as a single computer file, in my home, under the protection of a password
- the list was to be deleted, and tapes either wiped or destroyed as soon as the project was finished
- tapes would be transcribed under conditions of confidentiality and a transcription would be sent to each interviewee for comment and/or correction

- all transcriptions and material used in the analysis would not have names transcribed and only the two-letter code would be used to identify each respondent
- anyone not wishing to answer a question would not be pressed to do so and all information would be given voluntarily - anyone wishing to end the interview was free to do so at any point
- subject to interest, a copy of the final thesis would be available to people taking part.

After making this presentation queries were answered and doubts were confronted as openly as possible. I then asked the CPNs present if they would be willing to take part. Where an individual felt that they did not feel able to take part there was no pressure put on them and they were thanked for listening to the presentation.

There were two main issues which appeared to affect the response to my request: firstly, my status as a senior manager responsible, at that time, for Information Management and Technology, which also included analysis of activity data, and, secondly, my familiarity with the team. The South Durham Trust had been formed immediately prior to the fieldwork and was composed of the old South West Durham, covering Wear Valley and Sedgefield local authority areas, and South Durham Health Care which has covered Darlington and Teesdale. The CPNs working for South West Durham knew me well whereas those from Darlington and Teesdale did not.

The main fears expressed were that material which was revealed to me would be fed back to the Trust's management, given my post as a senior manager and closeness to the Board. The response to this was that, if even after my reassurances, anyone had reservations they should not take part. The initial meetings and "sponsorship" by senior nurses/team leaders who already knew me, referred to above, helped to maximise the trust between potential interviewees and myself. Another matter of concern was the use of the tape recorder: some people felt that even with the use of code identification a tape would be identifiable by the voice alone. My response was the same as previously - that

agreement to take part had to be dependent on their confidence in my reassurances. A final matter of concern was that of the content of the questions - I had avoided revealing any detail of what sort of topics would be covered apart from a blanket statement that I would be asking only simple questions about their everyday work and thoughts about their work. If this caused anxiety I reiterated the condition that all those taking part were free to refuse answers or information and could terminate the interview at any point.

By the end of the process, of 35 G grade CPNs, 30 agreed to take part: of the 30 agreeing, 27 agreed to tape recording of the interview but 3 people felt more comfortable with note taking only. Of the 17 CPNs I was known to only two chose not to be interviewed - the remaining 5 who declined to take part did not know me at all. The three people who preferred note-taking only also did not know me.

The interviews were conducted between the beginning of October 1996 and the end of September 1997.

Data collection

With the agreement of the interviewees, interviews were taped and, additionally, detailed notes were taken during the interview in case of problems with the recording. In the three cases which were not recorded, the notes were expanded to include, where possible, verbatim quotes about issues which appeared to be significant to the interviewee.

Using an interview as the instrument for my data collection made it necessary to remain aware that the interview is a negotiated interaction and not simply the mechanical transmission of information. (Silverman, 1994, Mason 1996) There are the issues of self-censorship, unwillingness to reveal potentially unpopular or damaging values and also the interview would offer the CPNs a perceived chance to use me for political gain. These issues were made acute because, at that time, I was perceived as being in close and frequent contact with the Chief Executive and the Trust's board of directors which could have both negative and positive

connotations for the interviewees. However, by being aware that an interview has several levels of communication, and by recording in my field notes any suspected attempt to manipulate the interaction by myself or the interviewee, it was intended to detect and allow for such effects when interpreting the material.

I also felt that I needed to remind myself that I was not starting with a blank sheet of paper but with pre-selected topics, with the proviso that interviews would not be limited to these topics which would also limit the chances of respondents introducing a topic of which I was not aware. Issues raised and defined as important by the interviewee, which were not on the topic list, needed to be pursued. Therefore, interview schedule used had a prominent reminder to myself to listen carefully as each topic was introduced and follow up on an response which was elicited whether or not it appeared immediately relevant - in this way possible links between values could be noted and explored.

General interactions which could be to be potentially revealing, although not exclusively so, were taken to be:

- criticism/complaints about anything,
- mention of holistic/humanistic/community care (definitions and understanding of these)
- relationships with medicine generally /GPs/consultants
- differences between CPNs and other areas/types of nursing
- issues of empowerment/helplessness/social issues
- issues of the origins of patients' problems
- use of jargon/technical terms: explore what they mean and why used.

On the interview schedule was also a standing instruction to myself to pursue anything which was not clear to me or which the interviewee seemed to regard as of burning interest when considering non-verbal language (including body language) or facial expression.

The interview schedule and interview conditions were tested in two pilot interviews with two CPNs who were not part of the interview sample. The people

concerned were part of a specialised service to a small and specific client group and were not in regular contact with the CPNs in the community teams. Apart from one question, which was incorporated into several other topics, there were no apparent problems and the two pilot interviewees felt that the coverage was comprehensive. A trial transcription and analysis of the interviews demonstrated that the interview schedule elicited a great deal of potentially useful material - a copy of the transcript was sent to each of the pilot interviewees who did not wish to add anything but both commented that undertaking the interview and reading the transcript had made them think about their practice although no further detail was offered.

After having done the group presentation with each of the teams, and achieved agreement to continue with each group of CPNs, an appointment was made with each individual CPN, usually immediately after the presentation, the exceptions being 5 CPNs who were not present at meetings but who were contacted individually later. In all cases a room at the team base was used both for the initial meeting and for interviews which, by intention, helped the CPNs to feel that they were talking on familiar territory and, because they often saw clients in the rooms, was an environment which has associations of privacy and confidentiality.

Interviews were held between November 1996 and September 1997 and were recorded using a portable tape recorder onto normal sized tape cassettes - each interviewee was shown the two letter code on the tape and container labels to demonstrate that I was keeping to our agreed conditions. A modified table microphone was used with the tape recorder being placed on the floor wherever possible for two reasons: to make the recording process as unobtrusive as possible, and to therefore minimise any discomfort at the thought of it being there, and for the practical reason of avoiding the microphone picking up the sound of the recorder's motor which had proved to be a problem in the two pilot interviews.

In case there were problems of sound/speech clarity, or tape failure, a full set of notes were also taken: it was not possible to make a verbatim record but all key

phrases and summarised comments were noted. Interviews were transcribed as soon as possible after they took place to enable notes, recording and transcripts to be listened to/read whilst still fresh in memory. This also meant that any issues or ideas arising could be used at the next interview. In the case of three interviews where the interviewee did not wish the tape recorder to be used more detailed notes were made and expanded immediately after the interview, usually within three hours of the interview.

In some cases, extraneous noise was a problem, because of the sensitivity of the microphone, but because notes were available and transcription was done as soon as possible after the interview, to supplement the notes from memory of the interview, no essential information was lost.

Data transcription

Because the tapes were full size they could not be used on a secretarial-type playback system with a foot pedal controlling the tape mechanism. Therefore the interview tapes were transcribed using the original tape recorder controlled by an improvised pause switch taped onto the computer key board to avoid time wasted in switching the tape on and off. The sound was fed through head phones both for confidentiality and to maximise the clarity of sound, given that I am partially deaf, especially when there was extraneous noise in the environment. As noted above, notes and memory were used to supplement the transcription where possible.

The pilot interviews were originally transcribed using the convention of indicating the structure of speech taking place - such things as pauses, emphasis, tone of voice, "ums" and "ars" and simultaneous speech (modified from Silverman, 1993). This convention is more appropriate to an analysis of the interaction pattern between speakers but was used for transcribing the pilot interviews in case it had value. A trial analysis of the pilot data showed that such information not particularly useful because I was looking for the meaning of the information given rather than the mechanics of the interaction therefore, given that including this information increased transcription time substantially, it was

decided not to do transcriptions this way for the main body of the work. A simpler system was used in which pauses were indicated by a line of dots, to retain the rhythm and breaks of the interviewee's voice - in effect acting as "speech punctuation" to maintain the separation of a series of statements and thus to preserve any non-verbal "meaning" as far as possible. Points which were particularly emphasised or where speakers showed tension or anger, for instance, were marked in the field notes and as a bracketed note in the transcript.

Transcripts were checked against the tape and then a copy was sent to each interviewee for comment. No significant additional information was returned spontaneously therefore to check whether there were any perceived barriers to contacting me, a sample of 5 individuals was approached and specifically asked if they wanted to add anything to the original interview material. Those approached felt that the interview topics had been comprehensive and that the opportunity at the end of the interview to add any extra material had been adequate.

The process of doing the transcriptions was also seen as the first stage of analysis in that particular themes and ideas began to appear, sometimes in the same context but also in different contexts which began to suggest ways of grouping the data for a more rigorous analysis. Separate notes were kept of themes and values as they began to emerge from the transcription process

When the interviews were complete and the transcripts finished they were converted to ASCII text in order to use the QSR-NUDIST analysis software.

Data analysis.

The chosen method of data analysis was to group all of the respondents' answers to a particular topic and then to examine the grouped answers for common elements and also for differences. Where there were references to other question these were noted to be followed up during analysis when trying to extract and describe categories or "themes" from the elements found in the grouped material. (Silverman, 1993, Mason, 1996, Cassell & Symon, 1994, Coffey & Atkinson,

1996). The notion of "themes" was preferred to "categories" (Bickman & Rog, 1998) because "categories" implies relatively fixed boundaries and a formal definition whereas "themes" allows for looser and varying connections between the initial "elements" found in the data. Some of the themes had become apparent at an early point in data collection and had been fed back into the questioning to gather further detail whereas other themes only surfaced during the analysis.

As an example of "thematic" grouping, respondents were originally asked about the difference between GPs as the responsible medical officer (RMO) in a case as compared with a psychiatrist. Answers to this also made reference to the way psychiatrists treated nurses in hospitals compared with how psychiatrists treat community psychiatric nurses. A second connection was the view that GPs are not well trained in psychiatry and psychology and that because of this GPs cannot either assess or diagnose mental disorders very well. GPs are seen as taking several different attitudes arising from their unfamiliarity with mental health: to dismiss such problems as unimportant with the risk of missing something serious, to "dump" them on the CPN and take little further interest or to insist on referring to the psychiatrist in all cases. The last attitude is also linked with a view about having to work hard to get a GP to trust a CPN's judgement which is facilitated by the CPN being based in the practice. A further related view is that the lack of GP training in mental health care means that the GP, when referring to CPNs, places a great responsibility on the CPN for assessing the case. Yet further this is linked with views about the autonomy such a situation creates for the CPN and gives them a role as "colleague" and "advisor" with some, but not all, GPs. The conclusion was that there is a set of views with the "theme" of "causes and consequences of relationships with doctors".

To maintain tight and systematic control of the analysis it was decided to use the QSR-NUDIST version 3 software programme because it simplified the task of grouping material under themes already noted when doing transcriptions. The Programme has the facility which allows the user to extract, group and cross-reference data almost infinitely, should an extended analysis be needed. Alternative schemes can be tried, and stored, more easily than with the

cumbersome and time consuming conventional methods of file cards, sticky labels and coloured high-lighters (Silverman, 1993). This software can be also used in an automatic mode to search for key words in a text but, as reading and re-reading the transcripts is an integral part of the process by which a researcher develops a sensitivity to the nuances of the data, the software was used only to create grouped extracts, and to cross reference text, always under manual control. For an interpretive study, the software is useful in enabling large volumes of text to be controlled and sorted easily but the automatic extraction of material using key words or phrases is purely mechanical and cannot replace the selection of material as "understanding" develops during analysis.

When all the transcripts were entered into the NUDIST program the "edit" facility was used to group manually the material relating to each topic area into a single document. This process involved reading through the transcripts for a second time, the first having been the act of checking transcriptions. At this point there was a growing familiarity with the material and some of the insights generated during transcription could be tested against the initial grouping of data. By reading the transcript and group responses, sometimes using only part of a speech section but at other times collecting the preceding and/or following comments which were needed to make sense of the material, the details of the themes emerged.

Each group of collected responses was described by a thematic label which briefly summarised the content of interviewees' responses. The labels were designed as a short description of the apparent cultural values as themes which had taken shape both during interviews and whilst reading the transcripts and notes. For instance, it was noted during the early interviews that there was a consistent use of the idea of people belonging to a professional "group", such as doctors, nurses and social workers, . Each group was seen as having different and distinctive views about mental disorder, as well as having a different function in the care of patients. This idea was later built into a theme about the way roles, duties, responsibility and accountability of the CPNs are defined and maintained relative to the other groups. Exceptional responses were also noted because these could indicate the existence of resistance to acceptance of cultural values or the

effect of particular individual experience interacting with cultural values to produce idiosyncratic views.

A comparison between differences and similarities in views expressed by respondents was made because similarities could mean that respondents were simply giving the "party line" in response to questions. However the apparent frankness of many responses, which were critical of the system or of other individuals, suggested that respondents were generally being open and honest.

Some of the themes, discussed in the next chapter, were foreshadowed by the literature, some emerged during interviewing, where they could be explored at the time, and others emerged from the analysis of the data. The themes are shown under separate headings for the convenience of discussion. They are not seen as existing independently but are treated in this way to allow a systematic exploration of the "pool of meaning" (Coffey & Atkinson, 1996) to which they contribute.

Chapter 5. Results of the analysis of the collected material.

Analysis of the transcriptions and notes made at the interviews showed there appear to be five major themes running through the CPN culture. These five themes also appear to be linked to the issue of professional identity – an issue that is fundamental in that culture. The themes are not exhaustive but, given the amount and quality of material collected, are the most apparent and appear to be significant to the people interviewed.

A brief summary of the underlying assumptions which governed the analysis of the interview material is shown before the themes found in the analysis are discussed.

Recap of assumptions.

There were several assumptions, influenced by Weber's work, which underpinned the analysis. The work was not intended to be a test of Weber, or any particular theory, but used the following ideas as a framework from which to begin the analysis of the material from the interviews. These assumptions are "ideal types" in the Weberian sense – their value is to provide a comparison by which deviations or variations from the "ideal type" can be identified and explored:

- the NHS is a large bureaucratic organisation with rational and impersonal rules which specify what the organisation does and does not do, the rules governing relationships between "officers" (doctors, nurses, administrators, those providing support services) of the organisation and those who are served by it (patients/clients/users),

- there is a clear hierarchical structure with clearly defined lines of accountability and responsibility,

- the work of employees will have definitions and rules which specify the responsibilities, duties and decision-taking capacity of people

who work for the organisation, as well as when decisions should be referred elsewhere and to whom they should be referred,

- at times of change, when the rules are being revised or modified, there may be individuals, "switchmen", whose ideas cause change to take a particular direction which then becomes relatively fixed in the culture,

- although the organisation specifies "duties" as though they are to be carried out by an "ideal" individual, the existence of sanctions for deviance from prescribed roles and duties plus grievance procedures for staff to complain about others or the organisation's treatment of them suggest that the organisation is also "bureaucratising" any anticipated mismatch between the ideal and the actual ways work will be done,

- there will be tensions in the organisation because the professional practice of clinical staff is regulated by other organisations outside the NHS, and because professional authority and objectives can clash with bureaucratic authority and objectives,

- there will be values held in common by members of the organisation which form a "culture" - a conceptual framework which allows members to communicate about their work and to explain and plan their actions. Within an overall culture understood by all members of the organisation, there will be a set of views and values constituting "sub cultures" which refer to only parts of the organisation's activity, and workforce, and can be expected to be more specific than the overall culture.

The above were used as a framework to examine the themes which came out of the data and to help with interpreting the structure of the relationship between themes. It was anticipated that the CPNs would have a set of views about their

work because they have a shared identity as a particular professional group: their title specifies that they are nurses with psychiatric training who work in the community. The notions of bureaucracy and culture raise questions, for example, about how CPNs may differentiate themselves from other psychiatric nurses who do not work in the community, what views they have about the community, compared to the hospital, what views they have about their specific client group, how they see their relationships with GPs.

It also became apparent during the analysis that control of the CPNs' clinical work was poorly defined and not specified or prescribed by the NHS as a bureaucratic organisation. There is a mismatch between the relatively well defined management structure of the CPNs' service and the style and clinical content of their work which is not defined by any detailed written specification but has grown in an ad hoc manner in response to the tasks they have been presented with as changes in the type and content of mental health care have occurred.

It is apparent that, whilst the NHS appears to be a bureaucracy, in some areas of clinical practice such as the community the "rules" are poorly defined and the precise definition of roles and duties becomes problematic. Even though post holders are clearly accountable to a manager, clear lines of responsibility cannot always be attained because of the blurring of medical, nursing and management issues for the person working with clients in the community (Lipsky, 1980). There is also a contrast between the control the NHS as an organisation can exert over nurses on the hospital ward, where there are rules and sanctions for deviance which affect most of the physical and social environment, and the community where much of the environment in which care is delivered is not under the control of the NHS and therefore the CPN. One significant aspect of working in the community situation for CPNs is judging when clients should be removed from the community to the more controlled ward environment. Also much of the work of the CPN is not as easily monitored or directly visible to managers as it would be in hospital.

Ideas from Goffman's work on "total institutions", noted earlier, were also used to frame the analysis of the data. One is the argument that nurses, during their training and work in a hospital, were "institutionalised" into the routines and culture of the asylum as much the inmates/patients. Nearly all CPNs had spent time on long stay "custodial" wards under a staff rotation scheme and many had trained and spent much of their career with the long stay patient group. One of my original questions was about what happens when nurses make the transition from a "total institution" which has strong controls for both staff and patients, where the patient is on the receiving end of the process and has little autonomy, to the community where the patients are, mostly living in their own home, are in contact with everyday reality and perhaps do not expect the nurse to "do everything" for them.

Another aspect of interest, already noted in my previous work and in day-to-day work with the CPNs, is the model by which mental health problems are explained. In the hospital there is a medical model approach, but in the community CPNs also use a psycho-social/humanistic model to explain some of the mental health problems in parallel with the medical model. The tension between the models was used as an interview topic during fieldwork and was seen as potentially useful for interpreting some of the data collected.

Themes from the interview data:

The main themes are discussed in the following sections: in spite of being shown as separate headings they are not seen as existing independently of each other but are treated separately to allow a systematic exploration of the "pool of meaning" (Coffey & Atkinson, 1996) to which they contribute. The data were initially grouped by the context in which they occurred - the topic of the relevant interview question which generated them. Then, noting where answers to different questions were cross-referenced to other issues helped links between the themes to emerge. The data were then re-read with the themes in mind to check for other links and more detail in the emerging analysis.

Illustrative quotes from the transcripts are shown in italics but no characteristics of individuals in terms of gender, training or length of experience are shown to ensure complete anonymity, as required by conditions of access to the CPNs.

Theme 1: Moving from being an RMN in hospital to a CPN in the community - and changing styles of work.

During interviews the CPNs identified several major factors in their experience of the transition to being a CPN from being a ward nurse which help to outline the differences and similarities between work in community and hospital nursing.

"... *it's two different ..types of work .. I don't class myself really as a nurse because I don't do what people would think as "nursey" things* ... [which are]..*I suppose putting things right for people...when people go into hospital ..they sort of drop their bags and everything that belongs to them at the door and the nurse takes over, the nurse tells them when to get up, when to go to bed, when to have their meals or a cuppa tea.. the nurse does take over when they're in hospital ..out in the community you can't do that because you're there to ..enable people to realise their own problems and realise what they can do either to put them right or to cope with them better...but you can't tell them what to do ...you're a guest in their house ..at any time if that person says "get out of here" you've got to go...* "

" ... *so the principles of it* [being a CPN] *are the same* [as a ward nurse] ..... *but the skills that are required are worlds apart* "

"... *the nursing training which I had trained me to .. follow a doctor's orders and look after a patient on the ward, make sure that they took their medication, observed them for any effects of that medication and observed for symptoms of the illness getting worse or better and being able to report that back to the doctor .. that's what I was really trained to do, to care for a person in a ward environment* ... "

The main aspects changing from hospital based psychiatric nursing to being a CPN can be summarised as the task of changing roles and building a new identity: there is an additional client group to cope with, who have problems which the CPN has no previous experience of treating. There is a new physical working environment, new social working environment with colleagues from a wider range of disciplines, a new social environment with clients and a different group of doctors to deal with. The professional boundaries of responsibility for both the client group and of the clients' problems are also less clear in the community where specialist mental health nurses (trained in behavioural and cognitive therapeutic techniques) psychologists, occupational therapists and social workers are all present. These aspects of working in the community contribute to the view apparently held by most CPNs that community psychiatric nursing is not like ward nursing, that they have to perform different therapeutic functions to those on the ward and that even the most enlightened ward nurse does not understand the task in the community until they have worked as a CPN.

"... totally different when you're working on the community .. you can't be there 24 hours a day to make sure that this is happening and that's happening and so on .. which again comes back to the fact that a person on a ward requires intense care .. that's why they're on a ward, that's why they're in hospital ..."

Every person interviewed found the work of a CPN to be a novel situation where the familiar authority structure of the ward did not exist and the relationship with patients was almost diametrically reversed from that on the ward. Instead of being "in charge" of the environment the CPN is typically stated to be "on the patient's turf" and needs to remember that "you are a guest in their home". Those who found the least need to change their practice were those who work exclusively with elderly people (6 of the 30 interviewees). They attributed this to the fact that range of problems found in elderly people was very similar to that found on the ward: mainly dementia, the effect of strokes (cardio-vascular accidents) and some cases of depression. The needs of the elderly clients in their homes are seen as similar to the needs they would have if hospitalised. The CPN perceive that for an elderly client at home there is the need for a carer, who is giving care in much the same way a hospital nurse would, who may have to

restrict the client's freedom and to exert some authority to restrain the client from particular courses of behaviour. The main change in the nursing work noted by CPNs caring for the elderly was that carers do most of the task related work at home which the support nurses would do on the ward. However, considering the needs of carers of elderly people, and supporting the carer, is a major addition to the work of the CPN compared with ward nursing.

" ...you've got a captive audience basically in the hospital but when you deal with people in the community you've got other things to deal with ... so you've got to be aware of .. the people you're visiting and the other constraints on their time ... their life styles .. and the family's around more .... and you got the other hazards of television, cats, dogs ..."

For the bulk of the CPNs (24 of 30 interviewees) who work with the general population under 65, the fact of being in the patients' home "as a guest" is a complete reversal of the ward situation with several consequences. One of these is an explicit awareness of the client's right and enhanced ability to say "no" to the CPN when the client is in their own home "on their own turf". This causes some difficulty when the client is seen by the CPN as being "mentally ill", usually with depression or a psychotic condition, especially when she/he is thought to be at risk of self harm or harm to others. At this point the CPN may have perhaps to act against the client's wishes about hospitalisation and invoke the Mental Health Act - "to come over all nursey" was the way several CPNs expressed this part of their role. Learning to deal with such events when the situational factors favour the client and do not provide the CPN with any kind of territorial authority is regarded as an important part of the conversion from RMN to CPN. All of the respondents who have met this problem claim that it can be overcome by "diplomatic" means coupled with a firm but insistent approach from the CPN, GP and, where needed, an approved social worker - sometimes it needs a consultant to visit the client's home to do their own assessment and add her/his weight to the persuasive effort. When persuasion is not sufficient the CPNs generally believe that compulsion is then justified.

"you look at people differently ... still got to care but you've got to be more objective and allow people to be more independent ... because you're dealing with them on their own territory .."

Normally, a nurse transferring from the hospital to the community will go through an induction period, varying in length from a few days to several weeks, during which the new CPN works with a more experienced person before assuming full responsibility for their own case load. With one exception, all CPNs' experience of their first visit a client's home on their own, after the induction period, gave rise to anxiety, fear and in some cases a feeling of not knowing what to do. *"Absolute panic", "what am I doing here?", "I had to make myself get out of the car and knock on the door"* are some of the ways the feelings were expressed. These feelings were in spite of having had experience, often extensive, of nursing intransigent, violent and disruptive patients in the hospital setting. The experience of being on unfamiliar ground and not yet having developed a strategy for coping with the situation, and of overcoming this problem, is seen as an element of what makes community nurses different to ward psychiatric nurses. The only exception was voiced by an experienced CPN who acknowledged all the other aspects of the transition to CPN but claimed not to have felt any problems or anxiety as she was *"clinically sound and well trained"*. Although all nurses must have had the experience, in training on the ward, of the first time they were left alone when treating a patient, this one respondent felt that there were no real differences between the work in the two different environments when specifically asked about this, although other differences were evident to her/him..

..... I can't say I've ever been frightened of going and talking to people .... so I didn't find that a problem ..... I would say that first going out into the community the biggest problem I found was accepting that people did have a choice ..... that going from a ward environment when the doctor was on site and ..... everybody did as they were expected .... to go out and talk to people and say "we've got this day centre" or we've got whatever facility ... and for them to say "no thanks very much .. I don't want it" ..... was a transition .....

Based on their own experiences and observation of others the CPNs believe that no RMN, however "enlightened" they may be, understands the world of the CPN until they have tried it.

"... the honest absolute truth - I was working part time in the day hospital and ... I used to see these nurses flitting in and out .. and I thought that seems like a great job .... it seemed to me, as people have said to me since, all you do is go off to Marks and Spencers and get your hair done every Friday and ..... I thought well, what a cushy number ... that would suit me fine .... so I applied for it ..... and soon found it wasn't quite like that ... "

The emphasis was on experience as a major factor in making the transition from ward to community - it is not something that can be taught even though the CPN Certificate course, lasting one year, was seen as useful by those who had taken it. The course mainly helped to challenge the RMNs' views that their skills were sufficient and challenged the use of the medical model although many CPNs were already seeking a wider model for understanding their patients when working on the ward. When talking about the reasons for becoming CPNs most of the respondents noted that they were dissatisfied, for a variety of reasons, with what they were doing on the ward - because they were newly trained as RMNs, and their training had been more innovative than the ward practice, because they knew someone who was a CPN and in some cases associated with a vague idea that they "were doing nothing for the patients" on the ward. The stumbling block was older, task orientated nurses as much as it was the doctors.

[when sitting talking to a patient on the ward] *"... a nursing officer came in - 'what are you doing lad, don't you have any work to* do?' *i.e. physical work, doing medicine cupboards, changing beds, you know, make sure the sluice is clean, checking the stock, but to talk to patients .. now I mean at the time my training, this is where you sort of got confusing messages, the school of nursing were taking about family dynamics and actually having conversations with patients .. finding out about the symptoms, the problems, the difficulties, why they were in hospital, what were their problems .. it conflicted with what was happening on the ward ....*

The CPN Certificate course was taken by many of the older CPNs including the two people who initially managed the service but had not been taken by many of the newer CPNs because of a policy decision taken by their employers at the time, to cease seconding CPNs to the course. This was possible because it is not mandatory for CPNs to have the qualification to be seen as specialist nurses unlike midwives, health visitors and district nurses. It seems possible that many of the current CPN views have their roots in the views of the older CPNs who contributed knowledge and ideas from their Certificate course to the CPN culture as the service was initially developing and growing but the CPNs themselves see this as only one of many contributing factors. There appeared to be little difference between the views of CPNs with the Certificate and those without it. It was not clear from the data whether becoming a CPN and absorbing the culture provided the ideas and knowledge which the older CPNs had gained from the course; this question remains unanswered.

"so ... *after 1 year did the CPN Cert at Sheffield which was useful as the placements gave experience of how other services worked\... it would be a waste of time to do it now ..... when I didn't have the experience ... I thought it would have been really valuable ... ".*
[Question: "... you feel that experience could replace the certificate?"]
"*I do yes .. good experience ..... and varied as well ... "*

The initial reactions to working alone were linked to one of the greatest differences between the ward and the community for a nurse, which is how the patient/client's problems are defined. On the ward there is a diagnosis and the doctor's instructions about medication and observation of the patient to be undertaken. A nursing assessment is also done to establish the psychosocial needs of the patient but this is dominated by the medically defined aspects of the case in the sense that the CPNs' view is a nursing assessment never supplants the medical assessment if they differ.

In the community, the initial medical assessment in the GP's referral letter is not given the same priority and the GP is usually not directly involved in the CPN's therapeutic activity. The treatment of the patient/client is determined by the CPN's assessment which is an extended version of the hospital nursing assessment procedure although there is no standard procedure in terms of the detail of the information collected - the similarity with hospital based assessment is in terms of the principles used. Thus, one significant difference between hospital and community based nursing assessments is that in hospital the nursing assessment is done alongside the (dominant) consultant's specialised medical assessment whereas in the community the nursing assessment may be done following a broader, less specialised GP assessment of a mental health problem. This autonomy means that CPNs have the responsibility of referring a client back to the GP for referral to a psychiatrist if a "mental illness" (e.g. psychosis or a severe depression) is suspected after assessment.

"... sometimes you get huge letters .. from some GPs perhaps it's because they've maybe known the person or they've got a history of mental health problems so they're able to sort of summarise that for you .. but now and again .. the information gets quite basic, I suppose they're saying that ", we feel we need assessment from yourselves, .. please go and do it' .. "

There is a universal agreement that whilst other disciplines, such as counsellors, support staff, occupational therapists and social workers can contribute to much of therapy offered to clients, the initial assessment is the exclusive preserve of the experienced G grade CPN who has the skill, based on their ward experience, to detect or eliminate the possibility of psychosis in new patients or to monitor the condition of a person already known to be psychotic. Detecting presence or absence of psychosis is seen as a critical task because it governs the approach the CPN takes - a psychosocial counselling approach or "nursey" supervision. There is a firm view that while people with psychosis can live safely in the community, the risk of the disorder causing them to harm themselves or others is much higher than with most conditions, apart from some forms of depression, and needs the care of a psychiatrist.

"... I don't want to put any of my colleagues down but I think that's the difference between a CPN doing a job and let's say an OT ((occupational therapist)) doing the job .... the OT I guess had got degrees of all kinds but she hasn't got the in-depth training and experience I've had in being able to identify mental illness ... and that's where I think my skills are ... I've got the skills to identify mental illness ... as opposed to other health problems ... so if somebody comes along with me today .. they're had an argument with their husband and they've split up and she's a bit depressed .... that woman's got a mental health problem ... somebody comes along to me today who is quite psychotic .. I'll pick that up and I know the signs... I think my training has stood me in good stead for being able to do that assessment ..."

This responsibility appears to underlie the initial feelings of anxiety when beginning to work in the community. This was sometimes noted as a "gut feel" or "instinctive" ability, which operates beyond the formal assessment procedure in the sense that whilst assessment may not show definite signs of problems, the CPN's experience allows them to "sense" that there "really is something there" which needs further investigation. The CPNs believe that this "gut feel" is a skill that a nurse needs to develop to be a CPN. It is linked to the view that in the community a CPN has to have a more "holistic" approach which places more emphasis on the client's social and physical environment than in hospital nursing assessment and care, even if they are taking a medical model approach to a "mental illness". Having the responsibility of doing the patient assessment and, if necessary, advising a doctor, the GP, is seen as a major difference in nursing practice which a new entrant to community psychiatric nursing has to learn to handle.

"... the hospital your assessment or viewpoint is fairly trivial .... it's almost insignificant ..... with the GP ... I feel that my opinion, my assessment, my view is held in high regard and respected and acted upon ..."

Another factor in becoming a CPN is moving from an environment where there is the ward team and presence of medical staff to one where these people are much more physically distant and less immediately available. Individual views in

this area differed depending on whether the ward experience was "good" with a sister/charge nurse who encouraged the new RMN to use their training to the full or whether the sister/charge nurse was task orientated and ran the ward as though it was a surgical/medical ward with cleaning, administering medication and "being busy" being more important than talking to patients. As quoted above, one interviewee recalled being told by the charge nurse *"if you have nothing to do go and clean out the sluice"* when he was found sitting with a patient on the ward. This was not in the distant past but had happened within the last five years although the charge nurse in question was seen as *"one of the old school who had no time for new ideas"*.

However, not all of the CPNs felt that working alone in the community away from immediate contact with doctors and other nurses was a problem although it was something which the new CPN had to come to terms with. The community team is seen as providing a CPN with a different, but sufficient, type of professional and social support which replaces the relationships and support found on the ward. Support is found both from the multi-disciplinary team in which the CPN works and, where they are attached to a GP practice, the primary care team is also seen as a source of support, although this is not the case for all of the CPNs.

Use of the words "client" or "patient" were linked with this aspect of a nurse's experience and also to the area in which the individual CPN had begun their working life. In the old SW Durham area the manager who originally set up the CPN service had insisted from the beginning that the word "client" be used always. One CPN commented *"he'd have slapped my face if I'd said 'patient'"*. The same manager felt that this was necessary to underline the difference between nurse-and-person-being-helped relationships in the community and in the hospital. It was noted that the CPNs who had been with the service from the beginning tended to use the word "patient" when referring to people being treated in hospital although they never used it when referring to their work as CPNs.

In the old South Durham area the original manager had not invested any great importance in this usage and staff who had started their CPN careers in this area

used the words "client" and "patient" interchangeably. Although the use of these terms was not pursued in depth during interviews usage of the two terms in the old South West Durham area appears to reflect a perceived difference between passive "patients" who are subject to the ward routine and active "clients" who are interacting with the CPN in the community. The term client also appeared to be linked to a "holistic" approach whereas "patient" was linked to a "nursey" approach. In the old South Durham area the insistence on holism is less marked and a more "medical model" approach was apparent in the CPNs' thinking which appeared to be linked with the lack of the "patient"/"client" distinction. CPNs who trained elsewhere showed a tendency to accept the established convention in the area they joined, although some dissented and followed the conventions of the place in which they were trained - there were two who insisted that "the people we see are 'patients' because they've come to us for help". The extent to which the "patient" - "client" distinction was made appears to be linked to views about the causes of mental disorder: as to whether the medical model is used to explain problems or whether a wider model with psychosocial elements is favoured. There was also a link, explored later with views about the legitimacy of individuals with psychological problems, such as anxiety, being treated by the CPN service.

yes .. there's a major difference .. one major difference .. that is really upsetting the whole of the community nursing ... we hit people at the GP practice when they were very .. mild problems .. we dealt with them and we never got into the long term mentally ill .. right? .. we saw ourselves as flying with "worried well" ... and we believed what we were saying .. this is a preventative thing, we're preventing problems .. we're curing them at secondary intervention ... "

When looking at training and experience in the hospital before becoming a CPN, it was found that the older CPNs with longer experience had the view that in the past a lot of charge nurses were "dinosaurs" and "just asylum Bobbies who wanted a quiet life". There was view that in the past a lot of hospital nurses expected eventually to be put in charge of a ward for docile long stay patients, with few symptoms, who were free to come and go from the ward and "needed little looking after". This type of post was seen as a reward for service as a

charge nurse on wards with more disturbed patients. In this situation new nurses coming to the wards were not allowed to bring in "new fangled" ideas which might upset the established and "successful" regime - successful in that running a ward without any problems coming to the attention of the senior nurse manager was believed to be the key to the "easy" ward on which to end your career. This was given as a reason why many of the original CPNs, who had worked in the community since the 1970s, wanted to leave the ward environment. They felt that nurse training in the 1970s was becoming more progressive and innovative but that the practice permitted on the wards was not and therefore felt that it was more likely that they could practise what they had been taught by working in the community.

".. all the different ideas and theories that people were talking about and using for a change, it felt yes this is right...you got so much theory in your training ..and you talked about this approach and that approach but once you got onto a ward it never seemed to get put into action ... everybody seem to talk a good job [local expression] *but because of the way the ward environment tended to be you're fairly restricted in what you could actually ...do... "*

Surprisingly, similar conflicts were also found by nurses who had qualified in the late 1980s, They also found that they were beginning their career on a ward which was managed by an older sister/charge nurse who did not approve of new ideas and maintained a task orientated regime. They believed that many of the qualities of the ward regime could be attributed not only to the "dinosaurs of nursing" but a lack of interest in new approaches in nursing practice by doctors, nurse managers and administrators.

"..because the nursing training which I had trained me to .. follow a doctor's orders and look after a patient on the ward, make sure that they took their medication, observed them for any effects of that medication and observed for symptoms of the illness getting worse or better and being able to report that back to the doctor .. that's what I was really trained to do, to care for a person in a ward environment .."

There were some gender differences found in the past which are less marked today. In the past male staff in the hospital worked with male patients and female staff with female patients. The CPN experience was that because many female nurses stopped work to have children, those women who remained tended quickly to become sisters in charge of a ward, with sometimes little more than a few months experience. On the other hand male staff tended to stay longer in the profession and a male nurse could spend many years as a staff nurse before becoming a charge nurse. The gender difference in career patterns was seen as significant by CPNs in that wards run by male staff were felt to be to be more conservative in approach and staff nurses, both male and in more recent years female, on such wards felt that they could do more innovative nursing in the community. Some CPNs believe that this was an incentive for men to become CPNs but this does not explain why female nurses who were ward sisters wanted to become CPNs. The female CPNs who had been ward sisters generally wanted to work in a less restrictive environment or, more recently, to work in the community because *"that is where the future is for [psychiatric] nursing*".

Hospital routines and the gender of the nurse in charge of the ward were associated with the feeling of loss of support when moving into the community and working alone. Some CPNs initially felt a loss of support and only slowly grew to see the community mental health team as a source of support and reassurance whereas others did not have strong feelings of loss when moving from the close ward team to the looser community team. The strength of feelings of loss of support was linked, by the CPNs, with the rigidity of the ward routine which to some extent was linked with the gender of the person running the ward. Some CPNs who had qualified more recently as RMNs and had worked on wards with rigid routines did not feel any sense of loss of support but attributed this to knowing more about the CPN service, which was already established when they joined it. Older CPNs did not have this experience as the service was feeling its way towards a definition of its role in the beginning: they experienced a greater sense of loss of support.

".. in hospital you've got the duty doctor on the end of the phone, you've got the rest of the ward staff with you ... out here you're on your own .. you've got tobe

able to make a decision and have the confidence to stand by that decision .... to be able to work with the autonomy we've got as CPNs ...."

The presence or absence of medical staff also gave rise to mixed views about the loss of support when becoming a CPN, which depended on the willingness of medical staff to include nurses as part of the ward team. There was also the factor of perceived competence of doctors, particularly junior medical staff. Where relationships with medical staff were good, and nurses were included in the medical assessment and care planning process, there was a sense of loss of support when moving into the community although in many cases this was ameliorated by hospital doctors' willingness to help with advice over CPN work. In the case of two consultants there was willingness to talk to a nurse as a "professional" when a CPN whilst the same person on the wards, as an RMN, had been treated by the same consultants as "a fetcher and carrier".

"... *the consultant psychogeriatrician valued nursing assessments as much as anybody's assessment .....*"

"..... *depends on the consultant actually .. with that person it's just "well discharge them to a CPN " ... but other consultants ... if you were working with them more closely did seem to have more respect for you as a CPN than they did when you were a nurse on the ward .....*"

Becoming a CPN was also seen as involving a change in a nurse's views about client expectations and the appropriate nursing response. The CPNs see their service as having a firm belief in holistic practice: the client's wishes and thoughts are an integral part of defining the problem and its solution.

Another CPN view is that clients going into hospital expect to be passive recipients of care and that nurses collude with this either by choice or are forced into collusion by the client's expectations. It was felt that whilst there is change towards a client-centred approach in hospitals the older values and attitudes are still strongly present in the ward environment because in some ways patient expectations provokes those responses. In the community the client may also

want to "play the passive patient" and CPNs expect to have to "teach" the client that the CPN role is not to be the nurse who "takes the problem away, fixes and brings it back OK". The CPNs' view is that the holistic approach is predicated on the client "making themselves better" with the partly disguised tutelage of the CPN who has, in turn, to learn to listen to the client and allow them to play the maximum possible part in their care.

For a lot of the problems referred to the CPNs the "holistic" approach represents a radical departure from the medical "disease" model used by doctors on the ward to explain and treat many problems where the "cause" is seen as some sort of biochemical malfunction which can be corrected by medication. This is an oversimplification because psychiatry itself is unsure about how far psychosocial explanations and techniques have a part to play, as has already been discussed in an earlier section. The new CPN has to learn that psychosocial explanations can be applied to all cases even when there is a "psychiatrist-type problem" present. However, if there is not then the psychosocial explanation has priority. (There is a view that GPs need to be "educated" into understanding this approach, this will be discussed in the section on relationships with medical staff.)

Responses to a question about what are the "ideal" CPN's qualities provided support for the process of transition particularly from the team managers who have the view that an RMN on the ward does not have the CPN's skills and **must** change if they are to be a good CPN. People who will not change are a liability; examples were offered including one person who was specified as being a good nurse but not the "ideal" CPN because of not having made the necessary changes in approach. The characteristics of the "ideal" CPN include the need to be self-motivating in learning new techniques and being constantly adaptable whilst working as a CPN. Equally, the ability to be a "good team player " was also strongly emphasised and linked with a view that "know-it-alls" and people who could not ask for help, or did not know when to, were never going to make good CPNs. These qualities are also important for work on the hospital ward but the point that was being made was that on the ward there are supervisory checks on such behaviour which are not so strong in the community where a CPN spends a lot of time working unsupervised.

Material from the answers to questions and the transition theme generated from this material were discussed, during a later interview with one of the original managers, who is not now an active CPN, because he was seen as a key "switchman" in developing the CPN service and had an awareness of the national CPN scene. My interpretation of the data was found to be both intelligible and acceptable to this respondent. It was also noted by this person that the CPNs' experience of the transition can be seen as a measure of the continuing difference between hospital and community practice which still exists.

This theme appears to be significant to the CPNs because eventually the analysis suggested that there is a linking theme about developing and maintaining a CPN professional identity with which many of the CPNs' views are linked. The way in which a nurse becomes a CPN suggests that their work and the expectations of them, by management, GPs and clients, are less well defined than the work of many other nursing and medical colleagues and this lack of definition is seen an enduring threat to the CPN identity especially at times of change in Government policy about the treatment of mental health problems.

The theme discussed above could be summarised: ward experience as an RMN is not sufficient to train a CPN, they need something more which appears to be learnt from other CPNs. As in other themes the values of the hospital and the views developed there are not replaced when working as a CPN in the community. Instead, additional values are taken in and views are modified, and extended. For some of the CPNs the tension in the hospital between "progressive" training and "old fashioned" practice on the wards was a factor in deciding to move to community nursing which may be why the CPN culture has "nursey" elements which have their origins in the hospital experience. Overall, there was no single motive for nurses wanting to become CPNs either for individuals or as a group. Individuals felt that they had a mixture of motives which contained the elements, in varying proportions, of seeking fresh challenges as people, seeking fresh therapeutic challenges as a nurse, dissatisfaction with ward regimes (both therapeutically and for the routine) and sometimes simply because they were sent to work in the community by managers.

Theme 2: CPNs' views on mental disorders and the nursing needs for people with mental health disorders - the dichotomy between "mental health problems" (MHP) and "mental illness" (MI).

One of the major differences between being a ward nurse and working as a CPN is the community is the wider range of problems referred to the CPN compared with that found in the inpatient population. This is because GPs, at the time of fieldwork, were able to refer directly to CPNs with cases of anxiety, or "life" problems which would not have been referred to a psychiatrist.

"... I don't know, I mean ... it's basically down to my nursing assessment isn't it ... and my knowledge of mental health .... somebody comes along ... with an anxiety state ... a mild reactive depression ... social problems .. those people I've got to be the counsellor for .. when you've got somebody who has schizophrenia, manic depression and the severe ones then I've got to be the nurse ..."

"... so the GPs will send absolutely everything and anything ... they aren't specifically referring severe long term mental health problems .. they are but they're referring absolutely everything .. so .. there is a lot of the acute work rather then the long term work ... we're a victim of our own success .... we said send them all so now they send them all and it's how I go to the GPs now and say, look, out of these 50 perhaps 25 need just a basic counsellor, these 25 need a G grade nurse ... and it's getting the GPs to recognise that difference in the two ..."

The data suggest that CPNs use a typology with three main divisions for categorising referrals,

- medically diagnosed disorders, mainly psychoses but including other conditions seen as having an organic cause, such as some forms of depression - medical model/biological explanation of origin (used by all CPNs) - classified as mental illness (MI) because the patient has a diagnosis from a consultant psychiatrist.

"... *often it is kind of administrating ... injections ... monitoring their ill health, I suppose ... you know, are they taking their medication, any problems with side effects, making sure that they get their reviews with the consultant, the doctors, it's a kind of facilitating all that really ....*

- a relatively diffuse group of "client defined" problems which are seen as reactions to adverse life events - seen as having their origin in the events of the client's social world and that these causes are known to client or can be elicited by a CPN during assessment (all CPNs use this category) - classified as psycho-social "mental health problems" (MHP)

  "... *generally when people come and they're psychologically intact .. they've got through their lives but things are such that something happens ... whatever .. that crisis point is and they've got problems ... they may come to us because the severity of the problem is such that they're not able to manage their life in any effective way .... or the problem's been around and they're getting stuck somewhere in their life .. the people that we get tend to be the people that have had* [these] *problems for a long time and may be on-going low mood or on-going anxieties ... they have those symptoms for lots of reasons and there's usually lots of things happened*

- "worried well" - people who are "dumped" by GPs on CPNs because the clients have no recognisable physical illness but persist in attending the GP's surgery - often seen as people with mild social problems - "little old ladies whose dog just died" - they are not seen as legitimate clients by all CPNs although some believe that if not seen at least once they could become "real" clients because untreated problems could become "mental health problems".

  [of worried well] "... *yes .. I would say that .... a majority ... I'm not quite sure how much of a majority ... but I would say a majority of people that are presented would fall into that category that is called worried well* ...[but] *often their health needs are as great as anyone else's .... they have genuine*

concerns about things that are happening in their lives ... they need an opportunity to have somebody help them look at things..."

The greatest distinction is made between psychosis and non-psychotic problems. Cases where psychosis is present are seen as well defined as they rely on a consultant's diagnosis which is accepted by the CPN. The view that psychosis exists, and that it should be diagnosed by a consultant, is not challenged although there are different ideas about how far a person with psychosis can and should be treated in the community. Some CPNs see the diagnosis as a form of "labelling" which produces a stereotyped response to the client/patient's needs from medical and nursing staff as well as the public and are keen to see the patient as having social needs in the same way as non-psychotic clients.

"... what we ... learned, and I still will not do, is work with diagnosis, I won't diagnose anybody .... what you assess them is what the problem is .. this guy is hallucinating, he's deluded, he thinks this is this .. but I don't say he's a schizophrenic .. I say he is a man with these problems ..."

"... I think you've got to involve education in psychosis <u>but</u> I think there are other components ..... and I think somebody who .. with new onset ... we should be doing more than just putting them on a certain drug .... we should be teaching them an awful lot more about how to manage their lives and keep their lives as near to normal as possible ..... and we should be trying to keep those people out of hospital if we can ....."

" ... I think there's always an element of risk .. I don't think you can keep people in psychiatric hospitals as a way of saying .. "we'll just cover our backs" .. that would be getting you back to the old asylums where everybody who just had a strange quirk was in .. there's people I know who .. have psychosis who have never been in hospital, they've been managed in the community all their lives with consultants and CPNs .. it depends what the hospital's going to do for you .. lots of people think you're going to go into hospital and suddenly be cured ... all that you get in hospital that you don't get here is 24 hour attention ... and do people actually need 24 hour attention and really when you're sat on an acute

admission ward are you getting 24 hour attention because half the time nobody's got time to talk to you ... "

In the case of "diagnosed mental illness" the medical model tends to be used to explain the condition which means that it is seen as a biological dysfunction which can be treated by medication and a "nursey" approach to care. Where the client depends on medication this is monitored by the CPN much as a nurse on the ward would, reporting on the beneficial effects and any side effects to the consultant or GP. "Compliance" with the prescribed medication regime is seen as very important and signs of relapse arising from "non-compliance" are carefully watched for. The client is seen as sometimes needing hospital care, because of the risk of self harm or harm to others. All but one CPN would have no problem with referring the client to the GP or consultant against the patient's wishes if the CPN felt that this is what is needed.

"...people with psychosis ... may need to go into hospital basically to have medication stabilised so that .. I think there is much more scope now for people not to go into hospital .. and although I'm sure hospital .. has always been seen as a last resort and perhaps is more so these days . .. but I do think that there will need to be some sort of inpatient facility ... "

There was broad agreement that keeping all clients out of hospital as far as possible is desirable and a major goal for CPNs in their work. However, with one exception, all those interviewed agreed that on some occasions it was appropriate for a client to be admitted to hospital mainly for changes to the medication regime, to weather a crisis or to give carers a short respite. The exception was a CPN who believed that all mental health care should and can be delivered to the client living in the community. This value was not an ideal but seen as a realistic goal - the main impediments to achieving it were seen as *"a reluctance by society to take risks, to want people locked up if they are different"* and a lack of resources for CPNs to provide the correct intensity of care. When pressed about cases where psychotic patients have killed the respondent countered with the example that we live with people being killed on the roads all the time and no one makes a fuss about it. When this view was fed back to other

respondents there was much agreement with it as an ideal but most respondents felt that for a small number of "seriously ill" or "damaged people" there was no alternative to residential care under compulsion and restriction if necessary. As most severe mental illness is chronic and enduring, residential care for this small group of sufferers can sometimes mean long term or life-long residential care.

Generally, long term care, as "long stay" in hospital, was seen as wrong even for people with active severe and chronic problems although there were some differences in the use of the term. For some people the distinction was not that all long stay care was bad but that long term residential care in an old style big old "bin" of an asylum was wrong and residential care could be acceptable if delivered in small community based units which had open access to the "normal" world. For others, there was no such distinction and all long-term residential care was to be avoided unless the client was physically unable to care for themselves, or had no one available or willing to care for them.

Clients were also seen as falling into more than one category because people with a diagnosed "mental illness" are seen as also having social/reactive problems both as a consequence of the behavioural difficulties arising from psychosis as well as more generally from their social world beyond the disorder - the two needs are interdependent but need different treatment approaches and the CPN can assess and treat the reactive problems without necessarily making reference to the responsible medical officer.

" ... you do look at a person as a whole person and not just the mental health part and to get the whole picture of the person and to facilitate someone's return to being able to .. return to being themselves and all their existence ... and it'd taking everything into account .. not just their mental health needs .. but.. their social needs and environmental needs .. how they are .. how they stand within the family and the community and so on .. and not just concentrating on one aspect but looking at everything ... "

The CPNs' category of "mental health problem" is derived using a variety of eclectic explanations, stated by them to be drawn from psychology and

sociology, as well as from psychiatry and their nursing knowledge, although sometimes without a clear reference to the origin of the concept. People with mental health problems are often treated using a counselling approach although some cases are referred to a Behavioural Nurse Therapist or Cognitive Nurse Therapist who are CPNs with specialist training, working under the supervision of a psychologist. Distinguishing which mental health problem category a client is put into depends on the CPN's assessment. All CPNs use the four stage nursing model, originally learnt in hospital but modified with experience in the community: assessment, care planning, implementation and evaluation of treatment. Medication is seen as undesirable for most mental health problems (apart from some depressions and other conditions, such as anxiety, at times of crisis) and clients are not seen as needing hospitalisation. The problem is usually categorised (not diagnosed) by the CPN and patient together. The problem may be outlined by the GP in a referral letter but the CPN would make independent judgement of the problem as there is a view that GPs can "get it wildly wrong".

CPNs believe that the responsible medical officer (RMO) plays different roles in MI and MHP: in the case of MI - the RMO is usually a consultant psychiatrist who makes a diagnosis, prescribes medication and has an active presence in the case. If the client is judged by the CPN to be not responding well to the prescribed treatment the client will be referred back to the consultant by the CPN either directly or via the GP. In the case of mental health problems the GP, as RMO, refers for assessment and remains ultimately responsible for the client's well being. She/he is advised of the result of a CPN assessment and the progress of the patient but the CPN categorises and defines the problem with the patient and then formulates a plan of care which is implemented without needing the GP's involvement. GPs vary between individuals in terms of how far they are actively involved in the progress of the case but with few exceptions the GPs do not control the care even though they are ultimately the RMO.

"... well, obviously the GP is the boss .. [at the] *the bottom, the GP is ... the responsible medical officer ... so you have to take note of what they feel the person requires ..but at the same time they're asking for your expert advice, opinion .. so they usually take note of what you feel as well"*

" I find GPs .. are very grateful of information you give them .. very grateful . "

This comes with some anxieties: [team leader] *"... it seems as if you have a lot of autonomy .. well at the end of the day you are accountable to the GP and you are accountable to the person that you're looking at .. now that's where the stress comes in .. because that's the bulk of the responsibility ... so I would not have a CPN who worked for me who would not report everything straight back to a GP .. we don't actually take on all that responsibility ... it may look like we do but if I have any cause for concern I don't go off duty until the GP knows that concern and he makes the decision ..."*

There are detailed differences between MI and MHP in the way the CPN functions.

In MI, the client is seen as needing a "nursey" approach (seen by CPNs as similar to the nurse role on a ward) in which nurse is delegated by a doctor to be "in charge" of the care and can involve a CPN over-riding patient's wishes when symptoms become "risky". The client may need to be told what is best for them and the nurse does the work for the client-as-patient: getting better is not just a matter of the client's psychological competence, even though the client is seen as maintaining the capability of living in the community. The CPN works with, or perhaps for, the consultant and/or GP and will be instrumental in hospitalising the client if it is seen as necessary or even merely advisable. One of the important parts of the CPN's assessment of any GP-referred case is the detection of psychosis, which is seen as needing previous hospital nursing experience There is a strong tendency to react as if nursing in hospital when the client does not wish to co-operate with the prescribed treatment and there is the potential for a relapse into "risky" behaviour as a consequence.

"... but when we do get ... a more severe long term client who is in crisis or has some ..... deterioration problem, I <u>will</u> go with them to the GP, I <u>will</u> do the nursey bits ... I think there's a time when you stop being a counsellor, an advisor and I step in and I do become the nurse because it's in their best interests .. they

have to go and get their medication changed, I'm not just advising, I'm saying now come along, I'm coming with you ... and it's getting the balance between the needs of the severe long term mental illness and perhaps the acute ... problems ..."

In MHP the client is seen as needing rapport, and a co-operative, negotiated approach to treatment, with the CPN advising, and guiding the planning of care, but with the client doing the work of getting better; the ability to recover is seen as lying within the client's competence. The GP is advised at all stages of the process but often this is only to conform with UKCC requirements for good nursing practice as many GPs are seen as not taking an active interest in psychiatric cases. The consultant is only used for occasional advice, if at all, and hospitalisation is largely resisted by the CPN as much as possible, not being seen as at all desirable except in some cases of depression when there is risk of self-harm.

Clients with mental illness, clinically defined depression and other mental health problems are believed to be "worthy" of the CPNs' time and attention -they are legitimate "users" of the service. The third group of people referred to the CPNs, defined as the "worried well" and the "persistent GP surgery attenders who have no detectable physical illness", are not seen by some CPNs as legitimate candidates for CPN care. The extent to which CPNs will help this group varied with geographical area of practice and individual views. There is a general view that all referrals must be assessed as a matter of good practice but if a referral is seen to fall into the "worried well" or "nuisance" category the Darlington area CPNs would refer the person onwards to a voluntary or social care agency. CPNs in the South West were more likely to see the person for a few more visits before referring onwards and were more likely to take an active role, for instance, in following up referrals to such agencies as the housing benefit officer, to the extent of helping someone to fill in a form and make a claim.

Generally, MI elicits a "hospital type" of behaviour which can justify denying the client's autonomy, involves working closely with doctors and has a medical model explanation of cause and treatment, whereas MHPs elicit a reaction in

which defending the client's autonomy is a priority and the problem is explained and treated using psycho-social models. There is virtually no challenge from CPNs to a medical model explanation of psychosis, and the appropriate response to it, apart from the one person who believed that good care in the community can prevent hospitalisation for **all** people with a mental illness. This CPN, when pressed, could only justify the view by the strength of his/her conviction. Otherwise, the biological basis of cause and treatment in psychosis (and for some CPNs, one kind of depression – "endogenous" depression), is taken as a "given" with little challenge. There is general agreement that if someone with psychosis is to live in the community they have needs for additional support with everyday life. However, the distinction between mental illness and mental health problems can still be found in cases of psychosis. To deal with the effects of the "illness", the psychosis, the CPN has to be a "nurse" but because the person with psychosis is living in the community the CPN has to provide care beyond the "nursey bits" and develop a care plan which acknowledges and covers all of the social aspects of the sufferer's life.

There are some associated general views that some GPs refer "worried well" because the GP "doesn't know what else to do" - the view that most GPs are not good at distinguishing "genuine" mental illness or mental health problems from social problems. In some cases specific GPs were seen as "dumping" people simply because "they don't have any physical illness that shows up on tests" and were referring to the CPN service simply so that the GP appeared to be doing something for their patient.

One of the commonest examples given was the *"little old lady who's lost her dog and can't get over it"* or *"people with normal bereavement reactions"*. There was concern that many of those referred did have problems because of *"loneliness, poor relationships, bad housing, abuse or just a shitty life"* but *"the ills of society"* were not seen as legitimate issues for a CPN to tackle. Three CPNs felt strongly that the "worried well" could become *"genuine clients"* if they were not helped with their social problems but this was not a general view - many other CPNs shared one respondent's view that *"we all have these bloody problems, I've got the mortgage to pay just like everyone else"* and that the problem was not

"the dog dying" but the referred person's ability to cope with day to day life and *"that's as much a social work problem as it is ours"*.

It is also a generally held view, close to a principle or article of faith, that all clients, whatever the nature of their problems, should be living as normal as possible a life in the community, in touch with their social and family network (even if this is dysfunctional and contributes to the problem). However, when pressed some CPNs cannot justify the view - it is an idea with the status of a self-evident truth - but others gave reasons such as avoiding the damage attributed to "institutionalisation" and it being therapeutically beneficial to live in contact with the everyday world. The idea of "community" is equally ill defined although most CPNs are aware of the academic debate over the definition and function of "a community". From the interviews, what CPNs are describing in their treatment of clients is that a large part of the CPNs' function can be described as the development and reinforcement of clients' coping skills and strategies to live in the community although some CPNs do not appear to see this as their function for all problems. The support of clients is seen as appropriate for people with "real" mental disorders but not their function for people with "problems of everyday life".

Another associated view, discussed elsewhere, is that GPs need "educating about mental health" and that the CPN can be effective in doing this through their assessment procedure which demonstrates to the GP "what is and what isn't" a legitimate referral.

One possible explanation of the dichotomy in CPNs' classification of problems is that MI is defined for them by a consultant psychiatrist and, following the dictum that a nurse does not challenge a doctor's assessment, the CPNs role is already prescribed by the consultant. This is supported by the perception (Prior, 1993) that psychiatry has been slow to lose its reliance on medication as the main form of treatment and the hospital as the centre of practice. On the other hand there are a lot of problems being referred by GPs, who are perceived as knowing little about mental health and also seen as not wanting to play an active part in the care of the client, thus creating the conditions for the CPN to develop a view that they

have autonomy as a specialist nurse. The GPs refer a variety of problems not seen on the ward for which the CPN has therefore had little training or experience. Medical theories did not provide any course by which a care plan could be developed. Paradoxically, the area of greatest autonomy for CPNs could be seen as in the area which they have the least skills derived from their hospital experience.

"... I suppose we are like self-managers out in the community so we would do our own mental health assessments .. our own plans, implementations and evaluations so ... obviously negotiating that with the people that we see ..."

"... I'll see a person, do an assessment and formulate my own .. ideas and a picture of how the person is , formulate my care and intervention around that .. I don't necessarily feel that I would need a consultant on a lot of occasions .. I don't think it would make any difference either way really ... "

The individual who started the CPN service in South West Durham in September 1974, and who managed the CPNs as a single service until 1987, described how the early CPNs in South West Durham were taken from the hospital ward and attached to a community unit, working with district nurses and health visitors. The team included a learning disability nurse who had already had prior experience with learning disabilities services which had moved to community based care before mental health services did and who could offer experience and a model for development. This respondent claimed that the experiences of this group of nurses showed that ward based nursing could contribute little to the development of CPN care apart from the 4 stage nursing process which itself needed modification for use in the community. In the hospital setting the nursing care plan has to accommodate the psychiatrist's prescriptions for care, including such things as the observation level and medication, and is formulated on the basis of the 24 hour presence of nursing staff. In the community a doctor's assessment may not be available and the client will not be under 24 hour supervision therefore the content of the nursing assessment and care plan has to take all of these factors into account.

The CPNs perceive that there are differences between their views when they were ward nurses and their views now as CPNs. One example is the extent to which they believe a person with psychosis or "diagnosed mental illness" is capable of living a normal life in the community. However, living in the community is still seen as contingent on the client taking their prescribed medication and the monitoring of that medication. This view, reflecting a medical model, contrasts with views about reactive, socially driven, mental health problems. There is a wide variety of models in use, although with little formal or critical appraisal of the borrowings. Some CPNs have a single perspective whereas others use several models depending on the problem. Most of the psycho social models appear to have their origin in formal academic training; the CPN can become aware of them by several routes: the Certificate course, attendance at short training workshops, following up conference or journal presentations or from discussions with other CPNs.

[on the usefulness of the medical model] *"..... I think we try and keep away from it, I think that's part of our training as well ... "*

[on the usefulness of the medical model] *"... I think that it has its place .. I've seen it work very well within the hospital setting ..... but I feel that the psychological .... more of the psychological and counselling approach is much better .... certainly within the community ... ".*

A major finding of interest in this area is the dichotomy between mental illness and mental health problems, in terms of the CPN's nursing response. This view shows that there is a strong link between hospital experience with mental illness and community experience with reactive problems. "Mental illness" is explained in biological terms, can involve long term medication and elicits a "nursey" approach where the client is seen as sometimes not able to take responsibility for their progress. "Mental health problems" tend to be explained in a psycho-social frame work, medication is to be avoided as far as possible and the client is seen as being in control of their progress.

The nursing approach to the type of GP referral for which there is no ward experience develops from a variety of sources and earlier hospital experience is modified by later community experience. CPNs describe this mixture of knowledge and experience as a "holistic" model of human mental functioning although there is no consensus about what the individual elements of the "holistic" model are. The picture is more one of accretion of views around the core of initial hospital experience which appears to be seen as the "valid" way of psychiatric nursing. One CPN was very open about this, describing his/her approach as the "[own name] *model of assessment and care planning*", which contained "*bits and pieces from everywhere*" and claiming that this was normal for all CPNs within his/her experience. However, most of the CPNs tended to use assessment and treatment models which were approved by their peers, teams leaders and external academic nurses although there is no uniformity or standardisation and the models are eclectic in content.

It is not possible to explore further the CPNs' views about the validity of the ways they incorporate knowledge into their practice because this issue was not pursued in depth during interview. This theme, however, raises the question for future work.

Theme 3: CPN practice is "holistic"

All of the first CPNs in South West Durham undertook a 1 year CPN Certificate course, in some cases before taking up the CPN post but not always. This suggests that an element of learning-by-doing with peer support has been present from the beginning of the CPN service. The mixture of formal and informal training experienced by the early CPNs was seen as helping to reinforce and formalise the holistic approach although the formal course was not always the origin of this philosophy. Interviews with CPNs who had joined the service more recently, particularly those who had been managed by the first CPNs, showed that they were explicitly aware that their holistic approach was originated and established by the first CPN manager as a personal philosophy as much as a professional one. Those who came even later to the service or who

had been trained elsewhere did not have the specific awareness of the origins of the holistic approach in South West Durham although they have had similar experiences elsewhere.

However, in the old South Durham area, centred on Darlington, the CPNs had been consultant led for a much longer period in the early period of development of the service and the originating manager there was also quoted by those who had been trained by him. The team still has a more medically orientated approach and although contact with the wider CPN scene has helped to encourage a holistic philosophy it is still more constrained and limited by a "medical" approach. This was shown in the view that referrals shown by assessment to only need counselling should be referred to a third party, often in the voluntary or private sector, whereas CPNs in the South West Durham area would see the person themselves.

However, the CPN holistic approach to the psycho-social needs of the "mentally ill" client can also be seen as an extension of RMN training and nursing models learnt on the ward, such as the Roper-Logan-Tierney model which emphasises the personal and social aspects of care. Newer CPNs have also encountered changes in their training which emphasise that the patient in hospital has needs beyond those defined by medical practice if institutionalisation is to be avoided. Both doctors and other nurses are believed to be instrumental in creating institutionalisation and several of the newer CPNs with more recent training noted their frustration about not being able to apply all their training on wards run by older staff with long experience of the "old way" of doing things" and this frustration drove them to work in the community.

When asked about the future most of the CPNs felt that their "true role" was the care of people with severe and enduring mental illness but on a much more independent basis that they did as ward nurses. The rise of such specialties as behavioural nurse therapy and cognitive therapy, as well as the presence of psychologists and counsellors in primary care, would lead them back to what they "had been put out there to do". Whilst CPNs have absorbed the mental-health-problems type of referrals they still have a firm belief that their "true"

place is "nursing" people with chronic and debilitating mental illness albeit using a much wider range of skills than they had when they were first set up. They believe that they should be seen as specialists and to some extent displace the GP in the care of people with mental disorders.

Theme 4: Relationships with medical staff - the change from working with/for consultants on a hospital ward to working in the community with GPs.

Much of the material collected from the interviews was about the presence and functions of the medical staff when treating mental health problems in any setting. One area of questioning was directed to this aspect of CPN views but frequent reference was made to medical staff in nearly all areas of questioning.

The issue of relationships with medical staff is interesting because in the hospital the "rules" governing nursing evolved during the twentieth century with the growth of psychiatry as a medical specialty and the transition of mental health nurses from asylum attendants. (Nolan, 1995, Prior, 1996). In the community there has been no formal definition of what CPNs should do or not do, nor is there a definition of how they should do it. (See Appendix 2.)This is the case at both national and local level (Brooker & White 1991, Ross et al, 1998). This means that a psychiatric nurse moves from a ward environment with relatively clearly defined roles for nurses and doctors, to the community where the nurse/doctor roles are much more fluid and negotiable.

"[of consultants] ... *gods they were, gods ... Dr A was totally different when you were a student to when you were qualified ... as a student on the ward she would walk past you and she would not give you the time of day .. other than to say 'where is the charge nurse' .. . if the charge nurse wasn't available she'd walk out again ... and I remember somebody saying to me that one day when they were a student, , Dr A wouldn't speak to her, next day she was qualified and actually acting sister, that's the way it was then, ... in comes Dr A and discusses everything with her .... totally fascinating ..* "

"...as far as GPs are concerned .... you've got to establish credibility with them ... in the early days it was the hardest task to actually get past the receptionist ..."

There are three main areas of interaction with medical staff: with psychiatrists and junior doctors on the ward, with psychiatrists in the community (for "diagnosed" cases, mainly psychosis and depression) and with GPs in the community (mainly for "reactive" problems). There are different views about the relationship between doctors and nurses in each of these areas.

The first thing that was apparent in the collated transcripts was that consultants in the hospital setting vary widely in their willingness to include nursing staff in the definition and treatment of patients' problem. In one case, quoted above, the consultant was influenced by the status of the nurse who was ignored by the consultant when a learner on the ward, was spoken to as a staff nurse on the day following achievement of Registered status and was included in the diagnostic/care planning process on the day, a few months later, when becoming sister of the ward. Another nurse found the consultant a "*real pig*" when working on the ward but as a CPN found the same consultant very approachable and helpful.

" ..but I knew and worked the odd shift for [psychiatrist] *in the hospital and I thought he was unapproachable, pompous and arrogant ..... and now I know him .... from working here and I've got to know him, the person and he's quite a nice guy .....*

In a further case the CPN had found the psychogeriatrician with whom she/he had worked with as a staff nurse "*very enlightened*". There was no correlation with the time at which the experiences had happened or the age of those concerned: some older consultants in the past were "reasonable" and some younger junior doctors and consultants today seem very hierarchical and dismissive of nurses both in the hospital and in the community.

"You don't have a chance to develop good relationships with consultants on the ward... things are improving... [but]*... consultants have more respect for CPNs than they do for hospital nurses because CPNs are more outspoken ... "*

"[of consultants about CPNs] .. *I think that they think we are essential but we're essential to more basic ... handmaiden type work ... I don't think they've changed very much at all .. ".*

Experiences with GPs also varied: unpublished analyses of GP referral patterns to South Durham Trust (routine management reports 1991 to 1995) showed that some GPs would prefer not to refer to inpatient psychiatry directly except in cases where violence or self harm were present or suspected to be imminent, normally referring to the CPNs or the CMHT. Others would not make initial referrals to the teams in the community, but only to psychiatrists. There was no apparent pattern of presenting patient symptoms which was used to make the decision to refer to either psychiatry or CPNs. Work was done (unpublished management report 1995) to establish the criteria GPs were using so that a set of protocols for referrals could be developed but it was found to be almost impossible because of the widely varying approach of GPs to psychiatric and psychological problems.

For these reasons the material about relationships with medical staff is complex and was treated with some caution. However, underneath the varying individual views expressed in interview, several common themes were found, most of which can be seen as concerned with the issue of the boundaries between medicine and community psychiatric nursing practice.

The major issue was that in the hospital the consultant, no matter how enlightened in terms of listening to the nurse's information about a patient, was clearly "in charge" of the case. This may be because medication is a normal part of treatment in most hospital referrals, whereas in the community many cases do not involve medication. This explanation is strengthened by the way in which cases in the community, where they do involve medication, consultant influence appears to be still strong. The issue of nurse prescribing was only mentioned by

two CPNs in this context, although it was clear that the right to prescribe medication was a major distinguishing factor between doctors and CPNs in the community.

"... I think the consultants ... in some ways have changed over the years ... but in the hospital ... we were there to do what the consultants told us to do .... they saw us perhaps as handmaidens ... come back and tell me and I'll tell you what to do next ...".

On the ward the consultant is seen as "god" and as well as prescribing medication the doctor also specifies treatment in detail including the level of observation to be applied to people who are deemed vulnerable to harming themselves or others. Current practice in the Trust, which has grown over the past two decades, relies on nursing staff to make an assessment of risk, but the doctor takes the decision about applying or removing observation and restriction on patient freedoms to leave the ward. The influence wielded by more junior staff, house officers, senior house officers and registrars, derives from the consultant role. What is clear is that no nurse feels able to contradict a medical instruction even if they feel able to challenge it by confronting the doctor with their perceptions.

"[of consultants on the ward*] it varied really .. from consultant to consultant ... some of them were very involving of the nurses ... they would educate the nurse during clinics and things ... and also they would listen to what you said but sometimes totally disregard it .... especially if it was a social thing .. if it was ... medical they were quite receptive to that but if you were talking a lot about social things ... then they sort of switched off..."*

"[on the ward]. *you followed the lead and .... often the medical staff never knew what the nursing care plan was ..."*

In the community, for "mental health problems" GPs do not specify treatment but leave it to the CPN's specialised knowledge to assess and treat the client although the GP remains the RMO. This creates a potential source of conflict or

confusion in which the "GP is boss", taking the medical responsibility, but does not direct or specify the client's care.

" .. my experience with GPs is that they put the referral in and ... it's up to you after that .... the only time that they're really do want to hear from you is if there's any problems and they're only too grateful to help out but I think that they're looking for us as professionals, that we know what we're about so they just don't interfere or anything ... "

However, the interview data suggest that this conflict is more apparent than real and GPs seldom intervene in a case beyond offering their assessment of the problem at the time of referral. If there is any disagreement the CPN will negotiate a new understanding of the case, based on the CPN's assessment, with the GP. Most interviewees have had some such disagreement but at no time do they recall a GP countermanding the CPN recommendations in the end.

"... recently, there has been a disagreement - I thought one thing and the GP thought the other ... but not a problem .. we can usually work through it .. they're very very approachable .... and they do not say 'no, I'm right and I'm the doctor' ..... they listen and say 'well, why do you think this' ..... and so it's a debate .... rather than an argument ... "

CPNs still openly acknowledge the GP's role as RMO - the "GP is boss" and take great pains to ensure that, for mental health problems, their assessment and treatment plans as well as progress of the case is communicated to the GP in writing. GPs vary in their interest in this procedure from an active interest, which is seen as relatively uncommon, to complete indifference which is seen as more common. The reason for continuing to provide reports is seen by the CPN as "covering their backs" if anything goes wrong and the GP tries to shift responsibility to them by claiming that she/he did not know what was going on.

".... the GP has to know what you're doing at every step of the way ... every single step of the way ...

" .. if there's anything untoward with anybody it really should be reported back to the doctor because he has ... responsibility for that person at the end of the day ..."

The CPNs' perception that GPs are *"not always good at mental health"* is worrying given that CPNs also believe that a large proportion of presentations at GP surgeries involve mental health problems. The extent to which GPs were willing to move from medical model explanations of mental health problems, and treatment with drugs, to psycho social models and referral to the CPNs, was seen as varying widely between GPs. Some GPs were also judged to be "dumping" "worried well" (people experiencing distressing life events) or "bothersome" patients (persistent attenders at the surgery who did not have any discernable illness) on the CPNs. At the time of fieldwork there was financial pressure to accept such referrals because under the GP fund holding system the referrals provided income for the Trust.

"... it was a progressive education of GPs as to what we as CPNs had developed our role to be ... there's been a lot of older GPs have retired and gone out over a 10 year period ... our family GP had been there from the day I was born .. and was still there up to 5 years ago ... now all of a sudden you've got a whole new influx of new GPs, of young GPs who are dynamic, more aware, have actually had experience of mental health ... we've got one ... who has a particular bent for mental health .. but the majority of the newer GPs are more aware ... generally speaking GPs are [now] *much more aware of psychological problems ..*

"... what a GP wants is .. to give me a referral and leave me to deal with it .. so he can just forget about it .. just like everybody else they're under pressure .... so the GP's expectation is from thereon you sort it ... they would say get on with it, I think it's basically because they've passed it to us while we resolve it, if we can't resolve it we'll get back to them and we'll say " .. this isn't our problem .. it's either for psychology or it's socially orientated ... refer it over to social services" ... but it's this pressure on GPs of having to see people .. and it'll take time, I haven't got the time, it's one for the CPNs ..."

With people in the community who are thought to have mental illness, the consultant still has an active role in the case and the CPN role mirrors that of the hospital nurse by monitoring "compliance" with taking medication, reporting the presence of side effects and any signs of a relapse into more active expression of the problem. The GP may, in some cases, administer medication with or without CPN involvement but generally medical control of the case is more pronounced and the CPN has to "follow" rather than lead.

".. . *we have a consultant here that does my clinic on a Friday morning and he's lovely .. you can ask him anything, you can ask him to see somebody at short notice .. but equally so he does the same with us and we work hand in hand .. you get other consultants who .. you say I think this is the best plan of action and they have their own agenda and .. you could stand 10 against one but they will make the decision ...*"

Nevertheless, the CPNs differ from the hospital nurse by producing a more extensive independent care plan which addresses the personal, psychological and social well-being of the client independently of the medical treatment although the medical aspects of the case have to be accepted as possible constraints and take priority over other needs.

"*... you've got your nurse assessment, care planning very much involves what a consultant might think and ... the ward I worked on was very much a multidisciplinary team, because we had a care manager, we had a psychologist and a behaviour nurse therapist and consultant psychiatrist .... so any care plan that went on was contributed to by all those people .... our role was just a part of that ... but in the community ... I found that the collaborative work doesn't happen as well ..... and so your nursing process is you identifying problems and how you're going to deal with them on your own ...*"

There is a similar care plan in the hospital where the patient's personal psychological and social well being is addressed but there are differences. Patients on the ward are more passive and "done-to" and the ward has its own routine which to a large extent governs the life of staff and patients. There is

now acknowledgement among ward nurses that the effects of a limited and closed environment should be minimised to avoid a reduction in patient independence and to avoid institutionalising them. However, the CPNs who have recently "come out" into the community all felt that however conscientiously they tried to maintain the patients' autonomy it is not until they worked in the community that they realise how limiting and limited the consultant-led hospital environment is.

In the community, formulating a care plan involved the client much more actively as they are still in contact with family and much of their everyday "normal" life which has to be reflected in the planning of care and treatment and in the role of the nurse: in hospital a nurse is on their own "patch" and has authority over the environment and activities in it whereas in the community the client is "on their own turf" and the CPN is "a guest in the home" with no rights or authority apart from at times of crisis when they may have to reassert the "ward" role and act against the client's wishes. For mental illness the consultant may be still controlling the medication aspects of the treatment but much more at arms-length and not in the client's immediate social surroundings.

".. *all the clients are involved in their care plans and they usually get a copy and it's always discussed before ... it's implemented ... they're involved in the care plan the whole time ...*"

"... *I think the tack I would take is to say this the care plan and what we do is a partnership rather than what I can do for you .. in fact I will frequently say it's 90% what you do and 10% what I do ..... and I'm a great believer on putting the onus and responsibility for the person's illness back in the patient's court ...* "

The CPN ethos is that they have the responsibility of maintaining the client's autonomy and "normality" as far as is possible but unlike the hospital they also see the client as being responsible for their own progress, even if it is under the CPN's guidance, which contrasts with the ward ethos which is still seen as emphasising the "do as you are told and we will make you better" approach. It is not clear how far this ethos has grown and flourished in the absence, or distance

of consultants, and the perceived lack of skills of GPs in dealing with mental health.

There is a subtle change in relationships with consultants who see people with mental illness in the community but there may be constraints on the extent of possible change. The consultants are generally more willing to listen to the CPN's information, and to use it, but still as a part of the doctor-defined prescription for treatment. The relationship has moved the internal balance between nurse and doctor but with little fundamental change which is believed to be difficult because of the legal and statutory allocation of responsibility.

"[the consultant] ... *absolutely in charge ... which I don't have a problem with either ... they're the responsible medical officer and they make all the decisions about the care but what I found offensive was .... I don't think there's really much recognition of the CPN as a practitioner ... that may be because they're used to nurses generally .. nurses carry out tasks, they're oriented to carry out tasks ... and .... if you look what happened in the community they actually found that .. the CPNs moved into the community and the psychiatrists only came to the community when they were pushed in the community.... they were hospital oriented and 'we're going to stay here' ... of course what happened to us because we took the service into the community ... there was a strong connection with the GP's practices ... and when the psychiatrists came out later ... but still want their power and ... they deal with things in that way ... I think it created quite a lot of confusion ...* "

The relationship with GPs is quite complex and appears to have been driven by policy changes in the NHS prior to and during the research. The policy was to move the emphasis on case management from consultants in the secondary sector of the NHS to the primary care sector. Even though a consultant takes over management of a case when a referral is accepted, the emphasis was on the role of the GP as the main care manager. This was not merely a shift in the locus of control of clinical management but also offered GPs control over commissioning of services and control of some funding of secondary services. (DoH, 1996) This was followed by more strategic policy which continued the trend of moving the locus of control of care to the primary care sector (DoH, 1996).

CPNs believe that GPs largely see CPNs as the experts in mental health problems and that, as noted above, GPs are generally not well trained in this area of care. Part of the CPN role is getting GPs "educated" to see mental health in a wider psychological framework, beyond the medical model and its attendant use of medication. There are two strands to the education of GPs - one is to get them to assess presenting mental health problems in a more sophisticated way and make appropriate referrals, the second is for the GP to understand what the CPNs are doing for the client. There is a view that when a new GP starts in a practice she/he has to be indoctrinated into "the way things are done locally" and if it is the GP's first independent post she/he will also need to be educated as to what CPNs are and what they can, and cannot, do for clients.

"... it was a bit daunting ... GPs didn't take easily to .. us .. we found it difficult .. because on the one hand we weren't doing what we were supposed to be doing .. and we didn't have any guidance .... so collectively we had to try and work out really what we thought our job was ... but it was continually knocking on GPs doors and saying to a GP .. "look, this is what we are about .. we trained in mental health .. or psychological difficulties" ..

There is a second view that in turn GPs do not accept a CPN just because the CPN has some qualifications and the right experience. There is a period during which the GP has to be shown that the CPN is skilful and can get results. There is a process of trust and confidence building that depends on the GP's familiarity with mental health in primary care and their growing confidence in the individual CPN's abilities. Personality and the social skills of the CPN are seen as crucial in the sense that "getting on well" with the GP is seen a critical factor in the professional relationship. This is sometimes accelerated if the CPN has the freedom and the time to socialise with the GP in the GP surgery common room - this is a way of establishing a professional presence as part of the primary care team and those CPNs who have the opportunity to socialise are accepted faster and more firmly than those CPNs who cannot. The requisite social skills and personality to get on with GPs were seen as an essential part of the specification for the "ideal" CPN.

"... once they'd got over the shock of somebody from mental health actually wanting to provide a service .... and come and talk to them .... they were wonderful but we set that up ... it wasn't something that we took over .... we set up things like weekly meetings ... or fortnightly meetings with the practices ... I think they're very useful ... all you do is sit and have a cup of coffee ..."

One interpretation of the importance of this mutual familiarisation process is that it is needed because there is no formal qualification or registration process involved in becoming a CPN, as there is for midwives, district nurses and health visitors, with which the GPs are familiar. The second difference is that, unlike the other nurses in primary care, the GP may not be familiar with the work and practice of a CPN. (Although contact with community midwives suggests that they do not see GPs as understanding the niceties of obstetric practice either.) The CPN is therefore subject to two conflicting pressures: the pressure to establish their standing as a specialist nurse and a legitimate member of the primary care team contrasting with the pressure within the CPN profession to work in a holistic, client-centred way which is in itself a denial of the exclusiveness of the medical model which is seen as driving the GP and other nurses. Several of the CPNs commented that they were under pressure from the GPs to "become just one of his nurses in the practice" and that if the CPN was practice based, rather than working from a team base, "they think that you belong to them and not the Trust".

The initial remit of CPNs was to care for people with established mental illness as they moved to the community helping consultants and GPs to monitor and maintain the client in a state of "normality" as far as it could be achieved. In some places, including the old South West Durham area, this included taking referrals from GPs for some mental health problems, such as reactive depression, to avoid hospitalisation. Most of the CPNs believe that as GPs realised that they could "dump" troublesome patients, who did not appear to have a physical illness, on some-one else, the level of referrals for mental health problems began to rise until it was the major cause of referral (internal management report: Reasons for GP Referral, 1996). The previous manager of the service also noted

the temptation of CPNs to collude with GPs by doing the "quick and easy" cases because it produced favourable figures (Korner statistics collected for the Department of Health) which emphasised the number of clients seen, treated and discharged.

In the South Durham area, around Darlington and Teesdale, the CPNs worked for the consultants as a hospital based team and did not begin to take referrals from GPs until the middle of the 1980s. (This could not be dated precisely because it happened piecemeal.) Once they began to accept GP referrals the same phenomenon of "dumping" began to occur but the response was more restricted than in SW Durham and interviewees stated (1997) that whilst they will accept all referrals and do an initial assessment they will not proceed further with cases which "just need counselling" and will refer on to another agency sometimes in the voluntary sector e.g. to RELATE for relationship problems. The CPNs in the South generally adopt a more medical model approach to assessment. One interviewee used the personal yardstick for anxiety that if the client was on anxiolytic medication they would be assessed and treated, but if they were not on medication they would get an assessment only and the GP would be informed of a referral onwards to another agency. GPs in this area were reported to accept the CPN's assessment without opposition.

Central policy guidance, during the period of fieldwork, about a primary care led NHS and the contracting method of distributing money in the NHS, particularly GP fund holding, also had an effect on the number of mental health problems being referred to the CPNs. There was an instruction from the Trust's Chief Executive to take all referrals for which a GP was willing to pay no matter how much the referral could be seen as "dumping" an unwanted problem out of the GP's surgery. Individual interviewees gave examples of GPs making this explicit when told that a referral was inappropriate.

The way in which GPs influence the type and number of cases referred to the CPNs can be seen as continuing medical dominance of nursing. (See quotes above) It can also be seen as part of the wider political changes in the relationships between consultants and GPs. One consequence of the changes was

that from the moment that CPNs were taking GP referrals they were being presented with types of problem that ward experience had not prepared them for. GPs are seen as regarding CPNs as general experts in mental health, compared to the GP, and if the GP did not feel a consultant referral was appropriate the CPNs were then the agency of choice. CPNs appear to believe that the original decision to allow GPs to refer directly to CPNs, without any agreed protocols or criteria for suitability of the referral, created the need for the CPNs to develop additional skills to cope with the wide range of GP referrals. To some extent CPNs have been pressured to develop their own assessment procedures, which do not include a consultant diagnosis as they would in the hospital, and which allow them to advise GPs when a referral is not suitable for the CPN service. This history also suggests that because the CPNs have accepted a wide range of problems, which include cases which a psychiatrist would not accept, and developed ways of caring for the referrals, the CPNs have contributed to many of the problems they have. "We made a rod for our own backs when we started letting GPs refer .. " was how one of the long serving CPNs viewed their work.

It is argued that the move towards a wider and less medical approach to mental health was started by psychiatrists in the ward setting (Prior, 1993) but they did not follow it out into the community as patient care began to become more community based. Paradoxically, CPNs can be seen as inheriting a consultant initiated development which then became separated from its origins with the accretion of psycho social material which in turn distanced the CPNs' thinking about assessment and treatment from that used by the doctors.

The apparent difference between the CPNs' views and GP's views about mental health raises a final point: the question of how do GPs and CPNs communicate about a referral? For meaningful dialogue there must be a commonalty of concepts and words to describe what the client's problem is and what is being done about it. Do CPNs slip back into medical jargon and therefore a medical framework when talking to GPs and is this a restriction on CPNs preventing them from moving too far away from medical/ward based values? There is some evidence that that CPNs experience some pressure to talk to GPs in medical terms that the GP understands unless the CPN can educate, or encounters, a GP

willing to take a less medical-model view of mental health. This evidence is not in what was said but in the context of "coming over all nursey" and having to "push" patients with chronic mental disorders into going to the GP even if they didn't want to, usually to have medication adjusted. The grouping of ideas about "being a nurse", involving the GP and medication seem to be opposed to the CPN being left alone to get on with care and GPs not being interested and the client having a mental health problem rather than a mental "illness"

Theme 5: Relationships with other professions and disciplines in mental health care.

Not all respondents could contribute their views on issues around relationships with other disciplines in the therapeutic arena because some of the interviewees, in the South Durham area, still work in CPN-only teams (9 of 30 CPNs) and have little direct experience of multidisciplinary working. Those working in the old SW Durham area (21 of 30) have worked in multi-disciplinary teams from 1986 onwards and all have some direct experience of this setting for their activities.

A major issue in this area of work is the division between social and health care which is mainly reflected in views about there being a political struggle for control of care delivery. Policies which require a single lead authority for long term mental health care (NHS and Care in the Community Act, 1991) were seen as being the reason for the conflict although no respondent appeared to have a detailed knowledge of the documents and discussion. The views were founded on observation of changes, "on the ground", to the service offered to clients by social work departments; the main change noted was the withdrawal of social workers from "non-severe" mental health cases and the lack of "welfare work" for people with non-severe conditions.

The CPNs generally believe that solving such things as housing problems and benefit problems is an integral part of the client's need for care - the CPN response is either to arrange for another agency to provide help or tackle these problems themselves if it is difficult to get help elsewhere. The creation of a

centralised access point for the County Durham social work system was seen as a particular problem as it inhibited day to day informal contact about clients which had previously existed between social and health workers in the field. The problem appears to be that the same social worker is not always dealing with a particular case and the CPNs were not told who would be dealing with a case when they contacted the access point.

Another issue is the use of other non-RMN trained health disciplines to treat mental health problems. CPNs believe that other health disciplines could perhaps learn to do safe assessments but, ideally, the initial assessment should be done by a CPN. They are convinced that they are the best people to detect psychotic problems because of their hospital experience and that only "reactive" problems should be passed to other disciplines with the CPN retaining severe problems such as psychosis and endogenous depression on their own case load. The CPN view is that an assessment by other disciplines is acceptable only if all new referrals are initially screened by a G grade CPN. The views about a clear distinction between "mental illness" and "mental health problems" show very clearly when considering views about the use of other disciplines to provide care.

"... what causes psychosis I don't know, I mean ... nobody knows do they ... I don't know the cause of psychosis .... but .. having had the background ... of a mental health training ... I feel I have got the skills to identify that ..."

"... anything that comes along here that's got any signs of risk factors, psychosis, medication a nurse has to pick them up ... in the team there's a group of core skills we've all got .. .. and as professionals there are certain skills each profession has got ... as CPNs we've got the skills in mental health assessment, long term psychotic users, medication, that kind of thing ..."

CPNs have also had an ambivalent relationship with psychology in that they borrow techniques from the psychologists, for such things as anxiety management, yet regard psychologists as being unsuitable for doing initial case assessments *"because they're not RMNs and don't always know what psychosis looks like*" - the psychologists do not necessarily have the ward based experience

which is seen as an essential part of the CPNs' experience. Some of the CPNs believe that people with psychosis tend to hide their problems and that "*they can be dead good at not letting you know they're mad as a hatter*" and therefore because psychologists are largely trained on non-psychotic cases they do not have the experience needed to detect psychosis which is being hidden by the patient.

In the SW Durham area psychologists were an integral part of each team. This allowed CPNs to interact with psychology and learn at first hand how to deal with many of the problems for which the CPNs had no ward experience to fall back on. Psychology is believed to be a somewhat "detached" discipline standing to one side of the medical world, particularly in the hospital, with roots neither in medicine or nursing in spite of strong links with them. It is not clear how this gave legitimacy to CPNs' borrowings from psychology but many of the borrowed techniques, for such things as anxiety management, were established by a profession formally "allied to medicine".

"... knowing what your role is ... it's important to know what you are supposed to be doing ... what helped me actually was ... working with a psychologist who I learned an awful lot from .... and I think this is the funny thing about the CMHTs and CPNs and the role is that you are exposed to other professionals so you don't necessarily go along a nursing path ..... from my point of view I become a lot more psychological... "

The CPNs have conflicting views because whilst they see psychology as a legitimate discipline from which legitimate borrowings can be made they also believe that psychologists give themselves "*airs and graces*". Some CPNs believe that psychologists see themselves as ranking with doctors as professionals in independent practice, but resent this because psychologists do not have extensive experience with psychosis as part of their training.

There are two formally defined nursing sub-disciplines, with their own certificated training courses, in which CPNs have taken treatment approaches from psychology and incorporated them into their own discipline. The two sub

disciplines are behavioural nurse therapists (BNTs) and cognitive therapists (CTs), taking their lead from applications of behavioural and cognitive psychology as the titles show. Nurses who qualify in these two areas are usually supervised by a psychologist. The CPNs interviewed did not offer any views about the two specialisms beyond acknowledging them as legitimate paths for a nurse to increase their skills.

".... if you've got somebody coming into the doctor's and saying ... I was abused as a child ... and I'm really finding it difficult coping with things at the moment ... you probably find that the GP will say ... would you like some counselling ... I am also a Rogerian humanistic trained counsellor ... and if I felt I needed to use a Gestalt or cognitive [approach] *.... I would be quite happy doing that ...."*

The BNTs and cognitive therapists show one way in which new techniques have become legitimately included in the CPN repertoire. Another way in which RMN nurses have reacted to the extra demands which are made on them when they become CPNs is the view that they have to expand their skill base on a "life-long-learning" basis to cope with the cases coming from GPs for which they have no relevant ward based experience. This is done by a mixture of learning from peers, educational workshops and use of journal articles. The legitimacy and validity of this process is not clear from the data and was not fully explored in the interviews but again is bound up with the MI and MHP distinction. Mental illness is medically defined and the CPN's RMN training provides the skills needed to monitor symptoms, medication and side-effects whereas mental health problems need extra skills which are acquired whilst working as a CPN. One consequence of working in a multi-disciplinary team is that CPN believe that the techniques of other disciplines can be added to the CPNs' repertoire.

Theme 6: CPNs and their apparent autonomy

The theme of professional autonomy links directly to the main theme of building and maintaining a professional identity. Professional autonomy is defined as the individual freedom to assess and treat patients limited only by the professional

body to which a person belongs and is by whom their work is validated. The data suggest that there is a poor formal definition of what a CPN is and what they should do and therefore the limits to autonomy are diffuse and negotiated/defined by reference to other, interacting, groups instead of being "given". The data also suggest that CPNs have achieved some autonomy in the absence of formal limits, but that the autonomy is to a large extent bounded by a series of constraints: the RMO role of the GP and psychiatrists, the requirements of regulatory bodies such as the UKCC, as well as self imposed limits.

It was noted earlier that there is a lack of any precise specification, formally defined by the employing organisation, for the contents of the CPNs' clinical work. There are policies, defined by each CPN team and agreed with their director and the Trust Board, governing such things as general conduct, record keeping, hours of work and response times. (See Appendix 2.) However, there is no written definition of the clinical conditions which CPNs can, or cannot, take on and treat, or what protocols are followed. Instead, there are two main factors which serve to define clinical practice; the CPN's training and experience and the referral patterns of cases coming from GPs and consultants.

Originally CPNs went into the community to care for people with previously diagnosed chronic "mental illness" but, as has been shown in a previous theme they began to take GP referrals for problems which would not have been seen on the ward and for which there was not a "psychiatric" diagnosis. This in turn meant they had to develop skills beyond those acquired on the ward; their own independent assessments were used as the basis of a care plan worked out between client and CPN only. The psycho-social needs of people with a defined mental illness were also provided for by the CPN although the medically defined needs of these clients, such as medication and its monitoring, had to be built into the care plan as well. The lack of an active doctor, in most of the GP referrals, when a CPN does an assessment and undertakes care planning/delivery creates the impression of autonomy but ultimately the doctor, whether consultant psychiatrist or GP, is "the boss" because of their RMO responsibilities. GPs are not seen as knowledgeable about mental health and are seen as very willing,

generally, to leave things to CPNs which helps the CPNs to see themselves as being the "experts" to whom GPs look for guidance.

However, as noted previously, in spite of a lack of GP involvement, CPNs spend an appreciable amount of their time ensuring that GPs receive regular written reports of the assessment, care plan, progress and outcome of a referral. This procedure is seen as a requirement of the UKCC's good practice guidelines but also serves the purpose of "protecting the CPN's back" by ensuring that the GP, as RMO, is given every opportunity to comment on the care being given by the CPN. Constantly updated documentation is also seen as a protection against accusations of poor practice in the case of legislation or an enquiry, both of which are believed to be a real risk when caring for people with mental illness or mental health problems. The insistence on complete and accurate documentation is certainly good practice, but the secondary reasons for doing it strongly suggest that CPNs understand their clinical autonomy to be conditional on the situation and that autonomy brings a concomitant responsibility for "getting it right".

The way in which CPNs organise their work in the community is very different from practices in the hospital setting. On the ward the tasks to be undertaken are enshrined in a ward routine which governs the life of both staff and patients and provides a structure which determines when and how everything is to be done. In particular, there are routines for checking how drugs and medicines are issued; drug dosages are checked by at least two people when injections are administered.

When a nurse moves to the community and becomes a CPN she/he achieves independence from the ward routine and gains autonomy in two areas - organisation of the individual CPN's own work load and how patient care is formulated/delivered. However, the individual CPN is not completely free to act as they please. For instance, there are national and Trust policy directives about how soon a referral should be seen for assessment after the initial letter is received, promptness in keeping appointments with clients and what must be done if the appointment cannot be kept. There are some constraints on the CPN

but these are less detailed and wide ranging than the ward regime for a hospital based nurse.

One of the most troublesome areas for the new CPN is giving an injection in the community. On the ward there is a thorough checking procedure, involving two people, for ensuring the correct drug and correct dose is being given. In the community the CPN not only has to give the injection on their own, as prescribed by the consultant, but has the sole responsibility for getting it right, without a colleague to check the procedure. This pressure has led to the development of a series of rituals which invest the whole performance with a startling solemnity. The equipment and drugs are kept in a small case known as the injection "kit" which is normally kept under lock and key at the CPN base. Secure storage is a requirement to protect the equipment from theft - CPN bases, like health centres, have become targets for burglary by those in search of drugs and needles. During field work I observed the "performance" of unlocking the cupboard, checking the injection kit and then preparing to go and actually give the injection, undertaken slowly and carefully, preferably with witnesses or colleagues there and never the subject of the bantering, self protecting black humour which accompanies many CPN activities.

CPNs working as team leaders also have a function in policing the CPNs' work. Although CPNs spend much time away from their colleagues and the team base, some of the team leaders exert a level of control over the work which is reminiscent of how ward sisters or charge nurses control their staff. All the team leaders have regular reviews with CPNs where the CPN's case load is scrutinised and the team leader expects to hear about progress and problems with all the cases on the team's case load. However, this is not the same as the charge nurse's command of the ward. The individual CPN retains control over the progress of a case and it is the quality of that progress which is reviewed and scrutinised by the Team leader.

"[we] *have a referral meeting and it should be the case ... as a G grade nurse I can take that responsibility and I'm getting paid to take that responsibility of managing my case load ... you don't get any stress or pressure or hassle from*

nurse managers ... we've all got to be accountable for our practice but we do that by being professional."

There is a recommendation laid down by the UKCC that all CPNs should have "supervision" every twenty working days where cases are discussed on a one-to-one basis, in confidence, with a senior colleague; difficulties and worries can be aired and any professional problems can be dealt with. In this way the autonomy of the CPN is limited by what is effectively peer review of their work; practice can be "harmonised" between individuals and any tendency to "runaway" or maverick practice is monitored. When talking about the qualities of the "ideal" CPN there was agreement that autonomy should be tempered by conformity to accepted good practice and any tendency to be a "know-it-all" was not conducive to good practice; there should be a willingness to both seek and accept help and guidance from colleagues. These views indicate that there are self imposed limits or constraints on the exercise of autonomy imposed by the group with the implied view that one "rogue" CPN could jeopardise the existence of autonomy of practice for all The emphasis on a CPN as a "good team player" also relates to providing support as well as receiving it through the team albeit at arm's length compared with the immediacy of peer support on the ward.

"... I want some acute experience ... I don't think we should be having CPNs straight from qualification ... I want somebody who's got some sound knowledge and practice behind them ... I want to make sure they're a safe practitioner before they actually come out here ... out here you're on your own .. you've got to able to make a decision and have the confidence to stand by that decision .... to be able to work with the autonomy we've got as CPNs .... and I think it's only by having a sound knowledge base and experience within a hospital setting that you get that confidence to do that ... I'm looking for a safe practitioner, someone with past experience ... so I want somebody with a bit of maturity, some life experience behind them ..... within the team I'd like a team player, somebody who isn't frightened to come back and look for help ... and guidance from other people, somebody who can work within a team, support their colleagues ."

A second implication is that the autonomy is believed to be conditional on concessions from others, in particular from doctors. There is insufficient data to fully explore the differences between medical and nursing autonomy but views about the GPs' lack of training in mental health and the reluctance of psychiatrists to move away from the hospital/outpatient clinics, firmly under their control, are factors which support the interpretation that CPN autonomy is derived informally from situational factors rather than being a formally defined feature of their work, with legal status. This is very different from doctors whose autonomy is well established and governed by statute law.

Evidence from other research (Pollock, 1993) suggests that CPN practice has elements of self justification which could be seen as protecting their autonomy and avoiding challenge from other disciplines. For instance, the insistence that a G grade nurse should assess all referrals before passing them to social workers and psychologists in the team. The emphasis found, in the current work, on good practice in recording in the notes, communication with doctors and the use of a formal nursing assessment procedure all point to a need to protect autonomy by such "self justifying" means because it has a fragile and conditional existence. Views about the efficacy of CPN practice appear to be linked to autonomy of practice which in this sense could be seen as "self justifying" because when asked what would constitute a "failure" to treat a person effectively most CPNs stated that they do not have "failures".

"... I don't think I ever get a sense of failure .... I certainly get a sense of disappointment... you saw someone a couple of times and then they just cancelled appointments or ... didn't attend ..... you're disappointed but I didn't think I was a failure because at the end of the day.... we haven't got a magic wand or a magic potion .... the work that has to be done has to come from them [the clients] *and if they don't want to do it then ... that isn't our fault ..."*

If a client is not making progress even when the CPN uses the correct assessment procedure and has the appropriate skills it is not seen as a "failure" on the part of the CPN or the model of care, but that the client either can't or won't co-operate with the prescribed or agreed course of action which will help them. If there is a

diagnosed "mental illness" present the lack of progress can be attributed to the disorder. When the case is one of a "mental health problem", a reaction to life events, then the lack of progress can be seen as in the client's domain because of the view that CPNs don't "fix the problem" but encourage and teach the client to "do it for themselves".

" ... there was a young girl, clearly ill with a psychosis and .. she wouldn't have anything to do with me at all ..... and I felt that I couldn't actually do anything for her ... I couldn't sort of physically get hold of her, I couldn't organise any sort of treatment around her, she didn't want our involvement and I felt quite frustrated with that ... "

It seems that any challenge to the CPNs' competence, both individually and collectively, is evaded and whilst CPNs believe that the "ideal" CPN is always striving to learn and improve their skills and knowledge they see this process as accumulative as much as challenging and replacing existing practice.

" ... know-it-alls won't make it, it needs an openness to new ideas and an openness to learning, the ideal CPN has to be sensitive to development all the time ... "

There is potential for further, more detailed, exploration of possible relationships between the motives for maintaining autonomy, the onus of having the autonomy and the efficacy of the CPNs clinical repertoire.

The linking theme: CPNs and their professional Identity

" ... there's always some-one nibbling away at the edges of your work ... "

Whilst transcribing and grouping the interview data it became apparent the responses to the interview questions suggest not only several major themes in the CPN's views but also a link which points to a fundamental issue which can be described as a linking theme for the other values. This linking theme is about

how CPNs express and articulate their concerns about their professional identity. Professional identity can be defined as the body of skills based on theoretical knowledge, skills which are acquired by training and examination, with practice which is overseen by a professional body. (Abercrombie et al, 1994) The debate about nursing having a professional identity, defining, maintaining or defending it is an ongoing theme in the literature both about nursing in general (Prior, 1996) and in community psychiatric nursing specifically (Brooker and White, 1993, Ross et al 1998).This issue underlies such issues as relationships with medical staff and other disciplines, the content of CPN practice, the type of client they should be treating and maintaining autonomy to practice.

The data show that as nurses moved from the hospital they came into contact with several new agencies who were either not present in the hospital environment or who were relatively peripheral to the ward routine. This expansion of the nurses' work, coupled with a diffuse remit, combined to create a situation where they appear to feel, the need to maintain boundaries with other agencies and disciplines involved in the care of people with mental disorders. The lack of definition of the CPNs' role and the content of their practice is very closely linked with the issue of professional identity.

" ... I think it is very difficult to define what we do and what we don't do .... because I feel our role's just expanding and I think the more that social services stick to certain criteria then they can say what they can and can't do ... health doesn't say that, health just carries along picking it all up ... then it begs the question of who's going to pick it up if we do that ... "

The key issue of a professional identity is *how* boundaries with other disciplines are derived and perpetuated either by statute law, custom and practice or by a mixture of factors inherent in the situation. (Lipsky, 1980) When discussing the issue of identity, the founding manager of part of the CPN service in South Durham made the comment quoted at the head of the section, in 1997 at the time of the data collection, particularly *"colonisation by social workers"* in response to government thinking about a single lead agency for the care of people with severe and enduring mental health problems (DoH, 1999). The concern was that

whilst social workers had a much clearer remit about what they should be doing, the remit appeared to be expanding to include much that was considered "health" care by CPNs.

As discussed previously, the present CPN role is the result of several inter-related historical strands: the development of psychiatry as a branch of medicine out of another branch of medicine, neurology, the invention of drugs which can be used to treat the symptoms of psychoses, the development of psychiatric nurses from custodial asylum attendants and the movement away from the use of large asylums to control "mad" people in favour of patients moving from hospitals, or not being admitted in the first place, to life in the community with medication and support from voluntary, social and health care agencies.

The increasing inclusion of psychological problems in the range of cases referred by GPs and others to CPNs, but not to a psychiatric hospital ward, has confounded the issue of CPN identity by adding the requirement for psycho-social intervention to their repertoire of responses. It is not clear why people with problems caused by life events were initially referred by GPs to CPNs and not to clinical psychology but it has been suggested by clinical psychologists that there were too few psychologists to absorb the work load and because of long waiting times such cases were referred to CPNs instead as they began to accept referrals directly from GPs.

In South West Durham the CPNs were able to take referrals for GPs from the beginning but in the Darlington/Teesdale area they only worked with consultant psychiatrists at first, monitoring medication and progress of people who had been discharged from the hospital. Only later did the Darlington/Teesdale CPNs take GP referrals and even at the time of interview they were markedly less willing than CPNs in SWD area to take on cases with psychological/reactive problems which suggests that the CPN professional identity has variable elements depending on the history of the team.

Of South Durham (Darlington/Teesdale LA areas):

" it's completely changed, it's completely switched the other way .. from [19]*74,... in the early days 90% would be referrals from consultant psychiatrists .. as the years went on and the service developed ..*[19]*79 .. 80 .. and 80/81 .. the balance was switching, it was changing* [to a larger proportion of GP referrals]"

Of South west Durham (Sedgefield and Wear Valley LA areas):

". as opposed to the rest of the community 99% of our referrals came direct from a GP, it was only a couple of percent that came from a consultant ... you would find hospital based CPN services in other areas where most [referrals] *came from a consultant psychiatrist and they didn't touch anybody that didn't ... "*

The main situations where the CPN identity is perceived by interviewees as having to be maintained or defended, appear to be:

- identity as CPNs in the broader spectrum of mental health nursing in the community
- identity of CPNs in interactions with RMNs still on the ward
- identity as nurses distinguished from other non-mental health nurses and other mental health professions
- identity in relation to people with MI in the community
- identity in relation to people with MHP in the community
- identity in relation to medical staff

"... but it was continually knocking on GPs' doors and saying to a GP .. 'look, this is what we are about .. we trained in mental health .. or psychological difficulties' ... 'I'm not quite sure who to refer to you' so I said 'well .. refer anybody you want ..just literally anyone and we'll take it from there' and that's how we got going .. so I mean we got people who were totally inappropriately referred... "

"...it's the role a person takes on when they go into hospital, they take the role on of a patient and the nurse is in the role of telling the patient what to do, where in the community it's the other way round ... the person can tell the nurse what to do and whether to stay or whether to go .. or whether to take any notice of whatever we said .. it al stays with the person .. we've got no control over it ...where the hospital nurse has ..."

"... I think really you'd have to start with having the management structure that understood what being a CPN was all about .. once as part of supervision I went to see [nurse manager] and he was... laid back, off the cuff remarks... he says 'it's all right for you CPNs .. you ride around in your smart cars, you go in folk's houses and you drink tea and coffee and eat biscuits' .. I says 'yes, and it's a bloody good life nearly as good as a nurse manager who sits behind his desk drinking his tea and his coffee and picking the phone up and having people running here there and everywhere .. I'll tell you what .. you set a week aside in your diary and you come out with me .. you can pick any week you like and you can be with me 9 till 5 and see what I do .. yes you can sit in the house and you can drink the tea that I drink and the biscuits that I eat .. at the end of that week if you can say to me 'well .. you've got a cushy job' .. well fine .. that's the offer I'm making' .. .. it really needles me when people make assumptions about a job they don't know the first thing about .."

Discussing the issue of identity is made complicated in several ways. There is no single, globally accepted definition of "CPN" shared by all nurses working in this field (Brooker & White, 1991, Ross et al, 1998). Within the Trust there is no formally defined work specification, although there are multiple implicit and explicit influences on practice and constitution of the client group. Also, CPNs do not work in isolation, from non-health professionals and agencies, as they did in the hospital; in the community there are influences from other professions and agencies.

It is unfortunate that in western scholarship there appears to be no single word or concept to describe how this situation happens, unlike Chinese historiographic studies where there is recognition of an essential jumble of causes and effects

found when studying human culture (Dawson, 1964). This is expressed in the Chinese word *sheng* (Mathews, 1947, character 5738) which signifies something like "growing in an organic manner from a multiplicity of causes which may or may not be apparent but which have visible effects".

Because of the inter-related nature of the various aspects of identity listed above the discussion will not rigidly follow the items in the table as a series of subheadings but will make cross references where they are seen as appropriate.

Looking at the areas where CPNs themselves perceived a need to maintain their identity suggests in nearly all cases the core experience as an RMN on the ward is an essential element for creating the CPN identity. In spite of this, some of the CPNs who were interviewed did not feel that all mental health nurses with RMN working in the community should be described as CPNs even though they were working with patients/clients. A distinction was made on the basis of having an RMN, experience of psychosis in the hospital and having served an "apprenticeship" in the community in order to have sufficient experience to deal with all the wide range of problems found there. For the manager who had set up and developed the service, taking and passing the CPN certificate course was a marker of the "CPN" as opposed to a "community mental health nurse" but many CPNs felt that the job could be learnt by working with an experienced CPN, and the team, absorbing their knowledge and experience in what could be seen as a tradition of learning by watching. This clearly shows that while the CPN identity may initially be founded on the RMN/ward experience there are also additional components, community experience and informal learning, if not certificated study, which are needed to define fully a CPN.

The identity of CPN-as-professional is expressed in the procedure by which all new referrals not already known to the team must be assessed by a G grade CPN because they have sufficient experience to recognise MI (usually psychosis or forms of depression). If MI is present the case is usually kept on the case load of the G grade whereas people with MHP are assessed and then their care is delegated to a more junior nurse or transferred to another professional who does not have RMN status. All the interviewees agreed that this was good practice

although two people felt that many of the referrals, who did not have MI, did not always need a nurse with RMN qualifications and experience to do assessments if the GP did not think psychosis was present. There was general agreement that MI was the preserve of the G grade with ward experience but MHPs could be dealt with by others, usually using counselling techniques.

There is an apparent paradox whereby CPNs are defined as RMNs with community experience of a wide range of mental health problems but the essence of CPN status is recognition and treatment of those with mental "illness" – those they have been trained to treat as an RMN in hospital. This tension appears to arise from a role conflict. The CPNs see themselves as nurses who should be caring for people with severe mental disorder but in the community, not in hospital, whereas the case load coming from the GPs has a lot of things such as anxiety which they are being asked to treat, in spite of the fact that they generally do not see this as an appropriate role. It may be that the existence of this role conflict is seen as a threat to the professional identity of a CPN by asking them to treat problems which are relatively minor.

In the Darlington/Teesdale area, there was more resistance to taking on cases which were seen as only needing counselling. However, the SWD CPNs had a wider and more inclusive view on what constituted a legitimate referral and were more inclined to accept cases where there was a MHP. The SWD CPNs would take a more counselling based approach. However, it was seen by all CPNs as a matter of responsible practice to undertake an assessment on all referrals to avoid any later recriminations of having missed a problem - several respondents openly saw this as the need to "cover your back" which implies that CPN autonomy is not as firmly established as it appears from their independent style of practice.

The team structure of G grade CPNs, under a team leader, supported by other less qualified workers, could be seen as reproducing the ward structure in the community in spite of the distance from doctors, compared with the hospital. This may be a common way of organising any complex set of work tasks as many situations are similarly structured. However, the need for a structure which underlines the standing of the G grade CPN in the nursing hierarchy suggests that

the ward-type authority structure is still seen as providing some reassurance that a CPN has parity of identity with hospital based nurses.

In the view of the CPNs, another threat to their identity and legitimacy is that nurses working on the ward, and many senior nurse managers above charge nurse grade, do not understand the CPNs' work. The different perceptions fall into two categories: the "social" aspects of visiting clients in the community and the differences in nursing practice.

The CPNs are concerned that ward based nurses believe the CPNs' work to consist of "driving about" and "drinking tea with the clients and having a chat". One respondent actually stated that this aspect of the work had been part of the motivation to become a CPN as an alternative to the slog of the ward routine. This person's subsequent experience in the community showed to her/him that the "tea and driving" picture was a myth. One respondent, quoted above, and who had long experience, expressed indignation that the director of nursing who set up the original team in SWD had always teased them about the "drinking tea and doing the shopping" aspects of the work. The director concerned had a bantering style of humour which was habitually employed in relationships with other nurses - "*he always wanted to be one of the lads*". Therefore the views expressed in humour, may have not expressed a genuine view, but may have contributed to the ward "mythology" about CPNs. The myth may have been perpetuated because the early CPNs in SWD had little contact with the wards once the team had been set up. The Darlington/Teesdale CPNs had had longer contact with the wards before taking GP referrals, but still feel that hospital nurses undervalue the CPNs' work and they, the CPNs, are badly misrepresented in the hospital setting both at ward level and for management.

There is also a view that the CPNs are undervalued on the ward because ward nurses do not have the experience of working in the community and therefore have no understanding of the difficulties of working there. Ward nurses are seen as not understanding the pressures and the responsibilities of the CPNs' work. Interview data shows that with two exceptions the CPNs all found changing from the ward environment to the community was a traumatic experience which made

them realise that as ward nurses they did not understand community based nursing even if they were well motivated to make the change. Because of their experience in making the transition, CPNs believe ward nurses cannot understand until they have tried it and that to concentrate on the social aspects of patient contact is misleading at best. CPNs learn to do without the immediate support of the ward team and the doctors' presence, and have the freedom to practice individually as they could not on the ward. They do not believe that the ward based nurses can understand the continuing responsibility imposed by seeing clients on your own, and making your own judgements, in the community.

The possession of additional training and qualification to work as a CPN is optional, not mandatory, and there were mixed responses to the need and value of extra training. The presence or absence of a "CPN Cert" did not appear to play a great part in the way CPNs define themselves within the community and hospital nursing situations.

Relationships with other nurses in the community, such as district nurses and health visitors, were not actively pursued in interview unless the CPNs chose to refer to them as part of their responses to other questions. What data was available suggests that the CPNs see themselves as "specialists" in mental health matters in the same way as other nurses have specialist skills in physical health. The CPNs can take referrals from other nurses but this relationship was not commented on with any emphasis in the study. This was in spite of the apparently dismissive rivalry, which was noted when I was teaching at the school of nursing at Winterton, between general and MH nurses about each others' preoccupation with a particular aspect of human functioning. A group of newly qualified RMNs remarked that RGNs on a conversion course to RMN were "*wooden*" and "*only good for doing as they are told*" and RGNs believed that RMNs and CPNs "*cannot remember their basic medical training*".

Where clients/patients are concerned, there are many views expressed about the need to maintain the CPNs' role by "teaching" or "educating" clients about what CPNs can do for the client. There are in fact two clear roles depending on whether the client has a MI or a MHP. If the client has a MI the nature of the

illness, in distorting rationality and therefore the ability to make informed and rational choices, is a major factor in their care and in the identity the CPN assumes. A client with MI is seen as giving the CPN different responsibilities compared with a person who has a MHP, which is not seen as distorting rationality in the same way as MI does.

A client with MI has probably had a period of hospitalisation. In the case of those with what is defined as a severe and enduring problem there may have been many spells in hospital and the possibility of a relapse with active symptoms needing further admission is always present. There will be a psychiatrist's diagnosis and even when the client is under the care of the GP any relapse will involve another referral to the psychiatrist. CPNs believe that their approach to the MI client group needs to be similar to that on a ward but with the addition of care for the psycho-social elements of the case.

In this context, one surprising view which was voiced, by several respondents, was that whilst the patient is under nursing care for 24 hours a day on the ward, but in the community is only seen for periods of 1 to 2 hours once or twice a week, the apparent difference in therapeutic contact is much less than it appears. There is some support for this view in that many of the CPNs decided to leave the hospital and move out into the community because they felt that nursing on a ward was about "being busy rather than sitting talking to the patients on the ward", especially for the less senior grades. One of the reasons for this is that the staffing mix on a ward has only one or two senior grade nurses with several less qualified nurses or nursing assistants who have the most contact with patients. The senior grades also have consultant rounds, paperwork, management and administration of drugs to do which detracts from patient contact. Several of the CPNs felt that whilst there is less patient contact time in the community compared with the hospital , even for very vulnerable people, the time spent as a CPN in one-to-one meetings is more therapeutically fruitful because "they have your full attention while you're with them".

However, in the community the CPN has to manage a joint identity for MI clients: monitoring medical aspects of the case as well as responding to the

psycho-social issues to maximise the client's independence and ability to cope with daily life in the community. The CPN has to monitor the effects of medication, often administered by the CPN themselves, and watch for signs of the disorder becoming active which means the CPN has to act in a similar way to a ward based RMN. Although a basic CPN view is that their practice must be client centred and never jeopardise the client's ability to take their own decisions they also regard the presence of destabilising symptoms of MI as possibly requiring them to act against the client's wishes and to play a part in imposing admission or treatment on the client.

The CPNs are aware of the dichotomy between their preferred psycho-social approach and the management of "risk" behaviour in the community. With established clients, where a good working relationship between the client and CPN exists, the potential conflict between "encouraging" and "custodial" elements is minimised by the client's trust in the CPN's judgement not to hospitalise them unnecessarily. In this respect CPNs believe that they are capable of assessing and managing "risk" behaviour in a more thorough and sensitive way than ward based nurses - they also believe that "risk" can be managed in the community and that people should not be hospitalised instantly even if, for example, they are possibly suicidal. CPNs see the ability to handle risk as an essential part of the CPNs' professional identity not shared with other mental health nurses, in the sense that in the community the risks are not being monitored with 24 hour care.

On the ward, even if the patient was not under close observation it would become apparent fairly quickly that they were relapsing. In the community such a lapse may occur when the CPN is not there and carers/family may not act quickly enough to prevent harm coming to the sufferer or others. Therefore the CPN assessment of risk has to try to anticipate whether a relapse is imminent. The emphasis on the need for assessment of new referrals by a G grade, the recording and quality of the assessment, for risk especially, can be seen as all part of the way CPNs protect their professional identity by showing that they are capable of safe and effective practice.

For clients with MHP, who usually are not diagnosed and labelled by a psychiatrist and would not be admitted to hospital, the CPN has a simpler role but one which simultaneously offers a substantial threat to their identity because care for MHP can be offered by many other disciplines such as psychologists or social workers. Because most of the problems in the MHP category would not be seen on a hospital ward and possibly not even by a psychiatrist at an outpatient clinic, the CPN has to learn and use extra techniques of care not directly based on ward experience. There is a complicating factor in that many of the CPNs also felt that they had been encouraged to take a broad psycho-social approach to mental health nursing during their training but that in their early work on the wards they were prevented from using a patient centred approach by the needs of ward routines and often by the sister/charge nurse ideas on what "good" nursing was.

It appears that the wider range of clients and addition of psycho-social and counselling techniques to a nurse's repertoire, when becoming a CPN, results in "layers" of new views which are added to the original core views about psychiatric nursing. The additional techniques, which are used by other disciplines, are central to the "CPN" identity but because they are not central to their original training and ward experience they do not add to the "nurse" element of the identity. When the CPN identity is under threat, from the pressure of blurred boundaries with other disciplines, the core "nurse" values appear to be the ones which CPNs use to identify themselves as "different", for example, to social workers or occupational therapists who are employing similar therapeutic techniques to the CPNs. This is linked to the way in which CPNs see themselves as retaining their "nurse" responsibilities for people in the community with "mental illness".

For clients with MHPs the CPN ethos of client centred care is fully expressed and CPNs are fierce in defence of the "holistic" principles which govern the care they give. In many cases however, the client has to be "taught" the CPN identity - to be educated and weaned away from a medical model approach in which the CPN is "expected to take the problem away, fix it and bring it back OK". The

CPNs' perceived role and identity has to be taught and maintained against the client's expectations of what the CPN can, or should, do for them.

CPNs are also aware of stigma possibly attaching to their role and to some extent tend to disguise the "psychiatric" and "mental health" label attached to their work preferring to introduce themselves to new clients as simply "community nurses" and encouraging GPs to do the same when telling the client that the GP wants them to see a CPN. The CPNs suggest that the deception seems to work if only to get a client to accept the first meeting with the CPN at which the CPN has two tasks: to overcome any resistance based on stigma and to convert the client to the CPN patient centred view that the client will *"do the work of getting themselves better with my help"*. The view was expressed as *"if you say 'psychiatric' they* [the client] *are off like a shot, you can't get over the doormat"*.

Dealing with MHP is not seen as truly "nursing" by many CPNs but as "community psychiatric nursing" which is not unexpected considering the lack of a clear remit and the external demands made on them particularly by GPs. When having to pressure a reluctant client with MI to see a GP or psychiatrist CPNs generally describe this as *"having to act like a nurse"* or more colourfully as *"coming over all nursey"*. When talking of "nursing" as distinct from "community nursing": the CPNs seem to be saying that proper nursing is really what RMNs do, or should be allowed to do, on the ward and that "community psychiatric nursing" is a different type of nursing altogether in spite of overlaps in approach. In several cases the implication from the CPNs' discourse was that "proper psychiatric nursing" is the original and most legitimate form of nursing. *"Community nursing"* of people with mental health problems appears to be seen as more difficult to justify as legitimate "nursing" because it does not always need the skills and experience of a G grade nurse.

The perception of two kinds of nursing appeared in the analysis of the original data but was not a specific topic for the interview schedule and would need more data to clarify some of the ideas which emerged.

There is one question on this topic which can be addressed - is the perceived threat to the CPNs' professional "nurse" identity happening with both MI and MHP clients or is the threat only because of having to include "community nursing" of MHP? The apparent answer is that it is happening with both groups of clients but for different reasons in each group. For "patients" with MI the presence of a psychiatrist creates additional constraints to which CPNs react to by acting more like ward nurses as well as acting in their patient centred role. For "clients" with a MHP the CPN has more autonomy, believe they are the "experts" and that GPs refer to them on this basis, but there are threats from other disciplines within the NHS and from social care workers as well all of whom can also take referrals for the care and treatment of MHPs. There is no group of patients or clients who the CPNs see exclusively - they are either an adjunct to medicine as a "nurse" or where they have the lead in the care of a problem which is referred to them in their more autonomous role as a CPN there are other disciplines, who are sometimes seen as competitors, also treating mental health problems.

The lack of clear boundaries between CPNs and other disciplines seems to be seen by the CPNs as part of the threat to their professional identity. There are three main groups within the NHS identified by the CPNs: psychiatrists, GPs, and other professions allied to medicine (PAMs - in this case mainly occupational therapists, clinical psychologists and specialist nurses with training in psychological techniques, known as nurse behaviour therapists or cognitive therapists depending on the type of extra training they have received). The perceived threat to identity from social workers is more diffuse and less explicit, and appears to have two elements: that social workers may be given the lead in caring for people with mental disorders in the community and secondly, a concern that the skills and training of social workers do not fit them for this task. although in the future they may be asked to undertake it anyway. The CPNs believe that without RMN training and experience social workers, and other caring professionals such as psychologists could miss vital signs of relapse in people with psychosis and therefore miss the rising likelihood of self harm or harm to others. The threat to professional identity is that if others without the CPNs' experience and training are seen as capable of caring for people with

severe mental health problems, there is a question about why CPNs are needed at all.

The dealings between psychiatrists and CPNs has already been discussed in detail above - one of the most apparent features was the variation in experience, between individuals, of the "ward type" doctor-nurse relationship. For some psychiatrists, nurses are there to fetch and carry on the wards but once out in the community are more like colleagues in the care of clients. However, this is not always the case - one consultant psychiatrist persists in seeing the CPNs as there to be directed as the consultant pleases which cuts across the previous more equitable way in which the team had become accustomed to working with consultants.

The main feature of the CPNs' views about their professional identity and psychiatrists is that they see psychiatrists as slow to accept the ethos of care in the community, preferring to cling to the hospital and the ward because traditionally consultant "power" in the NHS relied on the number of beds to which a consultant can admit patients. The extent to which consultants "ventured into the community" and gave up some of their dominance and became willing to work with the CPNs, especially in multidisciplinary teams, varies between individuals and to some extent, but not entirely, with age. CPNs see the extent to which consultants move towards patient centred care and a psycho-social model, instead of a medical model, of mental disorder as critical to acceptance of CPNs by psychiatrists.

For relationships with GPs, some of the same ideas also apply although a major additional element of the CPNs' views about their professional identity for GPs is the lack of substantial or significant training in psychiatry for GPs. They believe that GPs see them as "expert" colleagues in mental health matters and because they see GPs as relatively ignorant in this area even if sympathetically inclined, having a "psychological view". The CPNs' perception of GPs' views about the CPN professional identity is based on the CPNs' abilities to do a thorough assessment of the client which will define the problem much more accurately than the GPs can. There are two main areas where CPNs believe their

professional identity for GPs is in doubt. The first is the GPs who just "dump" any patient onto the CPNs when a physical illness cannot be found but the patient keeps presenting at the surgery. The second is GPs who do not use CPNs at all, either handling cases themselves, sometimes with the help of surgery based counsellors, or by referring on exclusively to psychiatrists.

The "dumping" of "nuisance" patients on community psychiatric services by GPs, claimed by the CPNs, is seen as reflecting a lack of understanding about mental health, and the CPNs' skills, by the GP. CPNs accept that they have to "educate" GPs about their role and the treatment of mental health in the community and that there is a varied response in the GP's' willingness to accept the CPN as an expert. CPNs find that with substantial social contact, GPs are more likely to refer to the CPN although there is a concomitant hazard that the GP may feel encouraged to regard the CPN as part of the primary care team in the same way as the GP has "his district nurse" or "his health visitor". (The use of the male pronoun for GPs was noticeable in all interviews which was almost the only time any reference to gender appeared in the interview material. It was not apparent whether the reference to GPs as "he" was because local GPs are dominated by men or it is the male GPs who are the problem. The only other reference was to one female GP who was noted as *"working well with the CPNs"*. Questions of gender and CPN - GP relationships deserve further exploration.)

GPs who do not refer to the CPNs at all are also seen as a threat to the CPNs' professional identity simply because they ignore the CPNs' skills and experience. Therefore, if the GP does not refer such cases to mental health services but treats them herself/himself it can be seen as a denial of the value and need for CPNs' skills. Part of the CPN reaction is also a fear that being under-used will raise questions about the CPNs' clinical role and value in treating problems in the community. There is also an ethical worry that clients could be being denied adequate or appropriate treatment given that GPs do not have extensive training in dealing with MI. This raises a concern amongst CPNs that GP do not always recognise the subtle early signs of relapse in people with severe and enduring MI on two counts: because the GP does not see the client frequently and because the GP does not have the CPN's experience of MI. There are further concerns about

GPs directly employing counsellors in their surgeries who do not have RMN experience and who are therefore not seen as competent to assess risk thereby risking inappropriate responses to the treatment of MI and MHP.

The presence of other disciplines in the community mental health team is acceptable to CPNs although with the limiting proviso that the CPN should always do the initial assessment of a referral before deciding that the case can be treated by a person from another discipline. There is considerable resistance to the idea of allocating cases to team members, at a team meeting, based purely on the referral letter, before a G grade CPN assessment has been undertaken. There are fears that psychologists do not have the CPNs' ability to spot MI but as they do not normally deal with MI on their own, but as part of a therapeutic team, there is a smaller perceived threat to the CPNs identity. Some CPNs, with additional specialist training in such things as cognitive therapy, are supervised by psychologists, and do not see the discipline as a threat to the CPN identity. There were only three specialists in the field work sample but it seemed that they did not consider themselves as part of the CPN group but as specialists taking selected referrals from the team. Non-specialist CPNs seem happy to ask for help from psychology, or cross-refer a case to them, but only when it is seen as relevant to do so. This may be because psychologists are in short supply and can not offer a service to enough clients to be seen as competition to the CPNs' view of themselves as the community mental health experts.

The threat to the CPNs' professional identity from social workers has already been discussed. Social workers are attached to some of the teams in the old SW Durham area but because of different administrative systems, and a lack of communication about cases referred to the social worker, they are not seen as full members of the team and the threat to the CPNs' identity and role is believed to come from policy decisions as much as actual practice on the ground.

In summary, there appears to be a considerable part of the CPN value system which is carried over from training and practising in hospital. The major changes are the CPN culture has values and ideas, which do not change the nurses' initial views about mental illness, but have a group of new views added to the hospital

based experience. Most CPNs, but not all, see being a CPN as going beyond hospital experience but not supplanting it. The medical definition of MI, which constitutes the majority of hospital care and experience, is not challenged but reinterpreted in a wider framework which has psycho-social factors which are not seen as instrumental as the fundamental cause of MI but are seen as "trigger factors", perhaps acting with inherited tendencies, to initiate on-set of mental illness and subsequent relapses. Mental health problems, MHP, on the other hand, are defined by a clear link between life events and adverse reaction in the clients' mental well being.

The CPNs appear to see themselves as having an identity as a distinct and distinctive group of professional care givers, because they have RMN training and experience, even if some of the work they do does not need that experience and those skills. They also believe that they have new and qualitatively different relationships with consultants compared with the hospital based nurse and as CPNs their role is to some extent defined by contact with GPs and GP referrals which makes new demands on both their relationships with doctors and their care of clients. The changes in mental health services in the years prior to the fieldwork, as well as changes which were taking place during field work, have created an environment in which the CPN identity is seen as under threat because the roles of all the professional groups are changing and boundaries are moving all the time.

The findings shown above will now be discussed, in the next chapter, in the context of other research shown in the literature.

Chapter 6. Discussion.

This chapter will first consider the usefulness of the theoretical ideas used in the early stages when formulating my questions and then move on to a discussion of the findings, the validity of the interpretation and finish with a review of how my findings fit with the literature.

Review of the theoretical ideas used in the research.

The initial decision to use Weber's "ideal" type formulation of a bureaucracy was found to be useful because when comparing the NHS with the "ideal-type" it quickly became clear that the NHS is not a single bureaucracy. It is a series of parallel and interlocking structures each with its own aims, agenda and rules - medicine, nursing, management and support services - which are all brought together for the purpose of providing health care and treatment for both physical and mental health problems.

One of the key elements of a bureaucracy (Weber, 1947) is that there are explicit objectives for the organisation, its reason for existing, and "rules" for how the organisation and those running it will act to achieve the objectives. The "officers" through whom the bureaucracy is operated are also expected to have a common understanding of its rules and purposes. Beyond this there will be experience of day to day operation and a body of interpretations of the workings of the "rules" in practice.

Putting together the work on culture and the definitions of a bureaucracy, I felt that groups of people working in such an organisation could therefore be expected to have a culture which would contain values reflecting the rules, structure and purposes for which the bureaucracy exists, as well as their day-to-day experiences. Furthermore, if the NHS is not a single unitary bureaucracy but is structured as a large organisation within which there is a series of distinct substructures then each substructure could be seen as a smaller bureaucracy within the larger one. The same reasoning as above suggested to me that the culture of a "sub" bureaucracy will also contain elements drawn from both the

"rules and requirements" of the overarching structure as well as from the smaller structure.

For my work this then suggests that a group of CPNs working as an identified "service" within a Trust, which is itself part of the NHS, would have a culture which not only referred to the practice of community psychiatric nursing but which was also influenced by the larger structure in which the service was embedded and by their background experience, in the hospital, of the CPNs . Analysis of interview material showed that many of the issues in the South Durham CPN culture were about the relationship of the CPNs with other groups, such as doctors and social workers, and with the larger structure, in such things as management of the service or the standard of record-keeping demanded by the UKCC and endorsed by the Trust management.

The findings also suggested that whilst the CPNs had moved away from the relatively rigid "bureaucratised" environment found on a hospital ward, the community based service was still bureaucratically organised - but in a different and less obvious way. The fact that CPNs spend much of their time working on their own with clients did not mean that their work is not supervised or "managed" in some way - there were major elements of the culture which addressed the tension of how CPNs cope with demonstrating that they are doing " a good job" when not under direct supervision or management.

A second useful insight was the link between Goffman's work and theories of bureaucracy which had been intuitively made during the formation of the research question. The link became explicit during analysis of the data when it seemed to me that Goffman was describing the experiences of staff and patients who were subject to the workings of a bureaucratic type of organisation, which, however perverse in the logic behind its rules, was acting in the way Weber described.

A total institution can be seen as an extreme form of a bureaucracy in action and therefore the link which had been made in the formation of the research question was about the influences on nurses of working in a mental hospital. A

bureaucracy can be seen as an "organisation with rules for undertaking activity in the everyday world" but a total institution is essentially an "organisation with rules for undertaking activity away from the everyday world". For patients in Goffman's work, there was little if any contact with the world outside the institution and for them the bureaucracy was their world. For the staff, there was contact with the "real" world in their everyday lives but they worked in an environment which was cut off from the outside. There is an issue about how far the separation of the "real" and "total" worlds in the working life of staff removed constraints on actions and judgements in the "total" world which would not have been acceptable in the "real" world. The situation that most nurses, and their patients, had experienced whilst working in the hospital environment was not as extreme in the isolation noted above but the situation was still perceived as having such characteristics. This was illustrated during the interviews by the comment from one CPN that "*whilst working at Winterton everything seemed fairly normal but as you drove through the gates at the end of the shift you realised just how odd the place was*".

During my analysis of the interview material, the value of using an "ideal type" theory of bureaucracy was that the differences between the "ideal" and the "actual" rapidly became apparent. This finding raised the issue of what views the CPNs would have about working in the hospital situation, in the light of subsequent experience in the community, what comparisons they would make between nursing in the community compared with the hospital and also what was required to make the transition between nursing on a psychiatric ward in the hospital and providing care in the community. In both the interviews themselves and the analysis, the comparison between "ideal" and actual bureaucracy helped several key issues to appear. A major one was that the work of a CPN in South Durham lacks a detailed and formal remit as to who should be seen and there was no formally defined or mandatory use of particular clinical assessment/treatment protocols. The way in which CPNs manage this lack of formal definitions, and their judgements about their practice, led me to the idea that professional identity could be a major theme in the culture, because of the changes in the provision of mental health care, both at large scale structural level and on a smaller scale in day to day practice.

The issue of "professionals" working in the NHS being subject to rules derived from external bodies, not under direct control by the NHS, also means that the NHS is not an "ideal-type" bureaucracy because, by definition, a bureaucracy has authority over all of the actions of its "officers" in carrying out their prescribed duties. (Weber, 1947, Waters, 1992) In the NHS all professions are also subject to an external body for the quality of their clinical or therapeutic work - the GMC for doctors, the Royal Colleges for each speciality, the UKCC for all nurses and so on. A member of a professional discipline is licensed to practice by a body to which the professional is responsible, and by which she/he is judged, for meeting stated standards of conduct and practice. This can be seen as a possible source of tensions for professionals working in the NHS, in terms of having their work defined by two apparently independent authority structures. (Reed, 1992)

In some ways, this departure from the "ideal type" is actually managed by the system: the individual professional is employed by the NHS under terms agreed with the professional bodies and as a bureaucracy the NHS requires that a professional employee has a valid and current licence to practice as one of the terms of employment thus providing the NHS with at least one, major, sanction over the individual. For psychiatric nursing, there is also a management structure within the main Trust structure whereby CPNs are subject to a set of rules enforced by a team leader who in turn is responsible to the locality manager, a senior nurse, who answered to the director of nursing, again a qualified nurse. In this way the CPN can be seen as enmeshed in a bureaucratic authority structure, staffed in the community by co-professionals, which has rules for such things as hours of work, qualification to practice and standards of personal behaviour with clients. Clinical work was also under scrutiny through the team leaders who asked for regular case reviews from each CPN, with details of client care and progress. Each CPN also has "supervision" with a colleague or senior to discuss problems or queries about their clinical work.

Another departure from the ideal type is the existence and influence of personal opinion and agenda brought to the work environment by the actors concerned. (Weber, 1947) In these aspects the behaviour of the "officers" of the

organisation is less than the rational "ideal" and can be pointed up by comparison of the 'actual' with the ideal. The role of personal values, the combination of values and experience, was seen in the analysis to take the place of a formal remit in shaping the CPNs' view of their role and threats to it. On a larger scale there were departures from the "ideal" type of definition of duties because of influences on the CPNs' views from the competing agenda and aims of policy makers, management needs, finance, medicine and nursing. (Lipsky, 1980).

The second aspect of Weber's work (Weber, 1947) which was used was the idea of culture - the set of views about the world shared by a group of people who are involved in a particular social situation. There were several ideas derived from the theory which were attractive for research on the social world of the CPNs:

- the CPN culture could be expected to contain concepts and ideas which would reflect the nature of interactions between the CPNs and the bureaucracy in which the CPNs work or have worked - this includes previous experience as nurses on a psychiatric ward as well experience in the community,

- for CPNs working within a bureaucracy their culture could have views about both the "ideal-type" aspects of the organisation and departures from the ideals which would be useful when interpreting the views and values of the CPNs,

- the culture was expected to show some differences, between individuals, in how views are expressed because of experience outside the work environment which interacts with the values of the group to form an individual's views - this aspect of the theory was also methodologically important because it allowed me to reconstruct underlying values from expressed views which differed from individual to individual. For instance, CPNs differed in their views about the risks and effectiveness of community based care for people with severe and chronic mental disorder. But, taken together with the finding that every one of them had some view on the

matter, suggested that community based care for very disturbed patients, was an issue and a "value" in the culture.

Having gathered data around the topics and any other views added by the CPNs themselves, analysis and interpretation was guided by reasoning that if views were related to the social world of the CPNs, the views would not be a "grab-bag" of random and unconnected concepts, but would show relationships and structure reflecting the structure of the CPNs' social world. The problem at this stage was to decide on the level of detail in the analysis: if it was pursued on too fine a scale there would be a mass of material in which it would be difficult to determine relationships, but if done on too broad a scale there would be the risk of losing the nuances and subtleties of the culture. There is also the matter of relationships between the individual and the CPN culture. The approach used was to look for themes in the material on the first pass through the interview data, based on the assumption that there would be structure and relationships in the material, and then, if themes were found, to revisit the data with the themes as a framework until all the detail appeared. The themes themselves were modified during this process until they were saturated and no more relevant detail was found within the data.

An example of the relationship between themes is that of doctors as agents in the care of people with mental disorders and the theme of the causes of mental disorder. CPNs distinguished clearly the role of consultant psychiatrists and GPs in the care of the CPNs' clients/patients. They also clearly distinguished mental illness, as being a biological dysfunction, and mental health problems as having a psycho-social aetiology. Within each theme was a lot of detail defining their views on the theme. However, the two set of ideas were not separate or isolated concepts. Rather they were related by views about the role of doctors in relating to each type of mental disorder. The consultants were linked with mental illness and GPs with mental health problems. The medical role is shown to be dominant in relation to mental illness but less dominant for mental health problems. These ideas had a marked influence on the CPNs' views on their role in caring for each category of patient.

There were views about the CPNs' role for each category of mental disorder, with a clear distinction between a hospital-type approach to mental illness and a broader counselling based approach to mental health problems. Another link, in detail, was the majority view that some hospital based care was acceptable for mental illness but should be avoided as far as possible for mental health problems. The views about different types of mental disorder were also linked with views about the ability of the client to profit from the CPN's involvement in the care of the client. There was also yet another link with the view that all clients should be formally assessed, as they would be in hospital, to distinguish the category of problem and that CPNs were the only suitable member of the community based team to do this - compared with psychologists, social workers or occupational therapists.

Overall, the theoretical underpinning of the approach was productive in two ways, firstly helping me to generate a broad list of the values and issues likely to be of relevant to the CPNs, and secondly in providing a framework by which to organise and structure all of the ideas and views described in the interviews. The theory of an ideal type bureaucracy was useful because it did not require that the data fit the model but allowed for deviations from the ideal to become apparent in the analysis thereby drawing attention to possibly significant areas of organisational behaviour. The theory of culture was useful in helping to structure the design of the research as well as being used to approach the analysis in a systematic and focused manner. Because the work was not a test of Weber's ideas there was no requirement to stay within the bounds of the theory but in the event the theories did not constrain or limit my research. The opposite was found: the theoretical considerations helped in the collection of relevant data and, through analysis and interpretation, to generate a coherent and detailed picture of the culture from the mass of raw data. These were not the only ideas which could have been used – had I been looking at the issues of status and power/authority several other theories would have been used: for example, Weber (1947) on class, status and power, Marx (1970) on the nature of social relationships or Giddens (1984) on how social structures are created and maintained. However, I was looking for a "rich picture" of the culture of an

identifiable group of people working within a large structured organisation. Therefore, the required theoretical perspective had to help me to describe and analyse the social environment in a way which produced answers relevant to the questions.

The first question: is there a CPN culture?

The first question for the research was whether there is a set of views, held by a specific group of CPNs, which could be construed as a culture - if there was no detectable set of commonly held views there would be little point in trying to interpret the data in the light of such a culture. However, the interview data and analysis support a positive answer. There is a culture at least common to the CPNs who took part in the research. The CPNs hold common views that constitute a framework for communication about, and explanation of, the world in which they work. Four findings underpin my conclusion that CPNs have a distinctive culture which has shared elements with the culture of other psychiatric nurses and also has specific elements derived from the CPNs' specific work and social environment.

Firstly, the topics chosen as a basis for the semi-structured interviews were taken from earlier work with the CPNs, from frequent contact with them as part of my job and from the literature. When these topics were presented as interview questions there was both a familiarity with the ideas and a consistency in responses which would not be expected if the topics did not reflect or tap into existing knowledge and beliefs. During the two pilot interviews one topic - the issue of "rules" by which the CPNs worked - was not found to be instantly comprehensible and was dropped from the list of topics. The intention was to explore views about the internal rules of the Trust for which the CPNs work as well as from such external bodies as the UKCC. However, during the main interviews the CPNs themselves offered information on this topic as part of responses to other questions. The problem appeared to be that the "rules" are taken as a "given" and not explicitly articulated as such. Apart from this one question there were few problems in establishing a discourse which CPNs accepted as relevant to their awareness of their work. Had there been problems

of relating my questions to their awareness it would have been taken as evidence that either there was no common culture or that the interview list did not contain appropriate and relevant topics.

Secondly, the collected and collated interview material also supports the idea of a CPN culture: there was a high degree of consistency between responses between individual respondents. The views they held were not always the same, for instance the extent to which a CPN felt that every client could be treated in the community without recourse to inpatient admission, but they all had a view that this was an issue for CPNs and that careful assessment of the client's situation was needed which had to balance the risks of non-admission against the damage that admission to hospital might cause. All of the themes and the constituent elements of, and associations between, the themes were familiar to all the interviewees.

Thirdly, there appears to be a local CPN culture because at the end of each interview each person was asked if they wanted to raise any other topic which they felt was important to CPNs. Apart from observations about being overworked and feeling unappreciated by management and, and sometimes other colleagues, no-one raised any issues not already covered in the interview. The view, in the majority of cases, about over-large case loads and insufficient resources such as lower grade nurses and secretarial support had already been noted during the interview. Without exception, each interviewee expressed the opinion that we had covered all the major issues of which they were aware. Within the interviews themselves individuals differed in the importance attached to each topic but there were no occasions on which a topic was seen as totally unimportant or irrelevant.

The fourth and final argument for the existence of a CPN culture is that the themes which emerged from the data were linked by the respondents in the sense that each theme emerged from the answers to several different questions and the same links were made by most respondents. If the link was not made by the respondent, but was introduced by the interviewer there was recognition of the link and usually more detail given by the respondent. By analogy with the

statistical procedure for assessing the probability of an effect arising by chance, it is argued that the extensive links found in the data during interview and analysis are unlikely to have arisen at random and that it is highly probable the links indicate that the CPNs have a set of views which are common to the group of respondents.

One overall feature found in the analysis is that the early hospital based culture has not been completely rejected and replaced with a new culture derived from in community based practice, even where the hospital based cultural values are seen as not appropriate to work in the community. Instead, the hospital type culture has been modified and new elements have been added so that the original values are embedded in a larger and more elaborate culture. Many of the values retain their original form but when coupled with the individual's values have been questioned and re-interpreted in a new context or framework but have not been abandoned. Much of the earlier culture remains present whilst the individual's views change radically as she/he gains experience of working with established CPNs in the community setting.

The second question: what are the constituent values of this culture?

The research findings, discussed in the previous chapter were seen as the answer to the second of my original questions.

The third question: how are hospital acquired views accommodated in the community framework and what effect, if any, do they have on practice in the community?

A major question for the research was that if there is a CPN culture, does it have values which reflect initial training and later experience in nursing in the ward situation? This question derived from reading Goffman (1986), discussed earlier, where the relationship between patients and staff was driven by the staff perception that the patients were, by definition, not capable of control of their lives and that staff had both the right and the need to "manage" the patients. This relationship, as described, is almost symbiotic for staff because without patients

the need for staff would not exist and without the rationale (rightly or wrongly) for committal of patients, the staff culture would not have the characteristics of "controlling" which were noted. This is not to claim that professionals working in the community do not "control" their patients. However, there is a substantial difference. In the hospital there can be a substantially greater control over the whole environment for 24 hours a day because the ward is isolated from the outside world. In the community it is more difficult for the professional to control the patient's environment because the professional is only with the patient for a short time and the client can make contact with the outside world more easily.

The concept and definition of a total institution suggested to me that psychiatric nurses working on the ward do not become controlling by whim or choice but have it imposed on them as an essential part of the situation in which they train and work. There is a perceived practice, perhaps established by the "rules" for running a ward, to "control" a patient and to organise the patient's life in accordance with the "rules" of the hospital. When a ward nurse becomes a CPN and works with people, as clients, who live and act with relative autonomy in the community, the nurse loses the means of exerting strict "control" over the patient's activities. The early surmise was that there would be some element of "bossiness" or wanting to take control of a patient in the community, of wanting to have the kind of authority over a case that would be found on the ward. A second possibility was the potential sense of loss and apprehension about not having the authority and the sanctions to "control" a patient-as-client.

The themes found in the research suggest that the CPNs' cultural values do reflect training in nursing in the ward situation, and that there is a carry over into the community, but not in the manner anticipated before doing the research. A slightly ambiguous situation was found: the CPNs have a view that the hospital is deleterious to a patient's independence in anything but the short term and they thus avoid hospitalisation as far as possible, however, they react to "hospital" type problems as though they were ward nurses. The key to understanding CPN-client relationships was found in the view that there are two groups of problems presenting to a CPN. There are clients who have a medically diagnosed

condition, which would be found on the ward, which needed a "nursey" approach because it was a mental illness. There are also clients with a range of "mental health problems", which would not normally be seen on a ward, and these cases are seen as needing a different approach where the client retains control of their care and treatment to the extent of having freedom to terminate contact with the CPN if they so wish. To a large extent the type of medical presence also has an influence on the CPNs' approach to their client. A consultant diagnosis is seldom questioned, at least not directly, and the CPN then acts like a ward nurse. If the medical presence is a referring GP the CPNs feel that they have more freedom to assess and be therapists who control the case. There are differences between the hospital and the community: on the ward the dominant medical staff are the consultants whereas in the community, if a consultant is involved it is at arms length, and whilst there are also GPs to deal with, they are not seen as having the same dominance as the consultant.

The nursing-style/type of problem connection was also linked with the question of who sets the objectives which will constitute an acceptable, if not "successful", outcome of care and treatment. For people with mental illness the goals are set by the psychiatrist and the objective of care is remission of symptoms, particularly through medication, and a return to "normal" functioning as far as is judged possible. On the other hand for people with mental health problems, the client defines the goal which may not be what the CPN expected. For example one client with severe and long standing agoraphobia had little interest in returning to a "normal" level of ability to leave the house, which the CPN expected to be the goal, but only wanted to have sufficient confidence to leave the house briefly to shop at a nearby DIY store in order to purchase material to support a hobby. The CPN gave this as an example of how they accepted the client's wishes in a way which would not be done on a ward.

Confusingly, it was found during interview and analysis that some CPNs use the term "mental health problem" for both types of case but from other contextual information they are shown to share the view about the distinction between "hospital-type" and "community-type" problems.

A second confusion came from the mixture of labels given to service users: some CPNs would only use the term "client" for everyone, others continued to use "patients" for everyone but the majority tended to use "clients" for the people they see as CPNs and to revert to using "patients" when talking about nursing in hospital. CPNs who used the term "patients" all the time also tended to have a medical model approach and did not see many of the "mental health problems" referred to them as legitimate cases for CPN care. On the other hand, CPNs who always used "client" tended to have a less medical model approach and to accept "mental health problems" as legitimate calls on their time and efforts. A further confusion was that given that CPN services in the catchment had come from two origins there was to some extent a historical influence which reflected the nursing "style" of the managers who created the service and which was related to some variations in views expressed by individual CPNs.

Another issue in my original question was the extent to which control, both nurse to nurse and nurse to patient, was carried from the hospital environment to practising in the community. Most CPNs were happy to be away from what many saw as the "dead hand" of outdated nursing attitudes and practice in the hospital and therefore did not miss the absence of tight authoritarian control. However, team leaders ensured that even though nurse to nurse control was looser, at arm's length, in the community there was a clear management structure with requirements to discuss practice and seek help with problems. The difference between hospital and community practice appeared to be that the individual CPN must be responsible in being aware of the limits of their own competence and ask for assistance when it is needed. One of the persistent ideas in the definition of an "ideal" CPN is that they must not be a "know-it-all" and also must be a good "team player", not only in terms of taking advice and criticism but also in terms of offering non-judgemental support to other members of the team.

Looking at nurse patient control, fieldwork showed that there was a three way link between type of problem, the CPNs' need to control a client, and the kind of medical presence in the case. For "mental illness" there is a consultant psychiatrist as the RMO and her/his diagnosis which labels the person's

problems. For "mental health problems" the referrals come from GPs and the CPN together with person referred define the client's problem, with the insistent view that this procedure did not constitute "diagnosis". This was not because of any difference in the vocabulary used to label problems but a matter of nursing-doctor protocols - because diagnosis was "what doctors, and doctors only, do". The links between consultant psychiatrist-mental illness- "nursey" control on one hand and GPs-mental health problems-client/CPN negotiation were very clear. What is not clear is how the CPN views arose - were they a response to differing expectations from consultant and GPs or were the medical staff responding to CPNs' own perceptions of their role and the role of the client/patient?

Overall it was found that there is a carry-over of the ward nursing style and role in the community but in a more subtle and complex way than had at first been thought. The influence of hospital training and experience remain, with some modification, mainly from additional skills and experience which are learnt, and "added on", plus the need to interact with a wider range of other disciplines who would not be encountered in the ward setting. There is a variable amount of modification of the ward-type skills in the light of later community-based experience - the degree of modification appears to be related to several factors: the "style" of the original creator of the CPN service, the age of the client and, to some extent, the attitude of immediate colleagues. In addition there are links between this finding and other views, which can be seen as a linking theme, which will be discussed below.

The linking theme.

There appeared to be a link between all of the individual themes which were seen in the analysis of the interview data: that of professional identity. This was not anticipated as part of the original research question but emerged during analysis. It is linked to the move from a relatively closed and controlled environment in the hospital to a more loosely controlled and more complex setting in the community. When wondering about the nature of the move from hospital to the community, at the early stages of this project, I was not aware that there may be a

weakening of a nurse's professional identity, or threats to that identity in the community.

The issue of identity was seldom made explicit in the interview but could be seen as part of the description of each of the themes which were relatively explicit. This is not to claim that there are no other common links between the themes but that the issue of professional identity appeared to be an active one at the time the CPNs were interviewed and also appeared to have existed for some time within the culture.

Taken together the themes suggest that much of the CPNs' culture is influenced by concerns about the boundaries of their work and practice which are not well defined and are as much a matter of custom and practice as they are prescribed by the organisation. The "rules" of the bureaucracy do not extend to all the detail of the CPNs' everyday working lives and they have to negotiate with other groups, both inside and outside the organisation, to define multiple boundaries for their practice. Some of the views about boundaries were derived from the internal structure of the Trust but, given that no organisation exists in a vacuum, there are also outside influences from other agencies, particularly Social Services Departments, who could be seen as competing for the care of the target client group. This finding is not unique to CPNs but exists for many people who work in similar situations (Lipsky, 1980).

Views about boundaries and identity were found to be quite complex. The view is that a CPN needs the RMN qualification and experience on the ward to be able to assess for "mental illness" but a person with this qualification and these skills is not necessarily yet a CPN. The distinction is that the person must also be able to assess mental health problems within a psycho-social model and to work with a client to formulate a negotiated care plan which is suitable for, and acceptable to, the client. However, somewhat paradoxically, care and treatment for people with mental health problems, as opposed to mental illness, is not seen as needing a G grade nurse and can be delivered by a lower grade of nurse or in some cases by a non-nurse. The additional skills which are seen as defining a CPN, as distinct from a psychiatric nurse working in the community and which can be

practised with more autonomy from doctors, are not seen as part of "proper nursing".

Links between the research literature and the findings.

This section will consider how these findings relate to existing research.

White (in Brooker, 1990) has noted the dichotomy found in the presenting problems for CPN services, between mental illness and mental health problems - in particular the increase in GP referrals to CPNs which do not involve, or require, the presence of a psychiatrist. Psychiatrists were noted as finding this process unwelcome and not being generally enthusiastic about community psychiatric services developing in the community unless they are running them. Tensions have been found in other CPN services because CPNs have to accommodate the interests of both psychiatrists and the increasing dominance of GPs, both for the good of their clients and for the CPNs' own professional standing.

However, whilst a similar tension was found for the South Durham CPNs, it was also found that a small number of South Durham psychiatrists were sympathetic to the CPN service and would work closely in the team with them although others maintained a distance between themselves and the CPNs. The "friendly" consultants were approachable, by CPNs, for advice and assistance. An additional tension was also found: that of individual GP preferences for the way they referred to mental health services. Some GPs referred all cases to the psychiatrist as a matter of course and would not use the CPNs directly at all. Others would refer the majority of cases to the CPNs for assessment, using the CPNs' advice as a "filter" to detect cases which needed referral to a psychiatrist. This shows that, in South Durham at least, the relationship between CPNs, psychiatrists and GPs is more complex than has previously been found.

The same research (White in Brooker, 1990) found a related tension in that CPNs themselves are "tugged" between the care of people with chronic and enduring mental health problems, who are often identified as a priority group for

CPN care, and the care of people with short term problems. Chronic mental disorders are seen as not rewarding because of the intractability of the disorder whereas short-term "psychological" problems can be "cured" quickly and are seen as rewarding although often, paradoxically, dismissed as "worried well". There appears to be a tension between the perception that "nursing" people with severe and chronic mental illness is what CPNs should really be doing, but treating people with less severe mental health problems, who can be "cured" quickly, makes the CPNs look as though they are working effectively.

The current work added some detail to this situation in that the CPNs experienced pressure from GPs to take more and more of the short term clients but were also pressured by psychiatrists and Trust management to increase the amount of work done for people with chronic disorders. At the same time the Trust would not decline GP referrals for relatively minor problems, particularly from GP fund holders. (Trust Policy.) The CPNs in the study had varying views about the balance of the work, ranging from feeling that their skills were best employed working with severe and enduring mental disorder to wanting to help with less severe mental health problems to prevent the person becoming more seriously ill.

There was also an association of the long-term patient with psychiatrists and the short-term client with the GP, who needs to be convinced of the usefulness of the CPN service, especially if, as a GP fund holder, payment is involved. This finding was also connected to the CPNs' clear distinction of "mental illness", because it is defined by a psychiatrist and elicits a "nursey" approach , and "mental health problems" referred by GPs which were responded to with a broader psycho-social approach.

Monkley-Poole (1995), on the evidence of a survey, argues that GP attitudes to CPN services are favourable and that they would like CPNs to be practice based. It was earlier suggested that this is the direction in which CPN services will eventually evolve (Pollock in Brooker, 1990), as is actually happening in 2002 as Primary Care Trusts are developing. GPs are also seen as becoming gatekeepers to all community based services and therefore in a position to influence the work

of the CPNs (Monkley-Poole, 1995). Detaching the CPN from the psychiatrist and the hospital, coupled with a lack of research on CPN services, may create problems for the CPN in retaining professional status. There is a fear that CPNs could be absorbed into the practice team as just another one of the GPs' "nurses".

When considering the issue of CPNs being practice-based, it was found in the fieldwork that the South Durham CPNs were highly aware of the GP in their work, and of some GPs' wishes to have the CPN based in the practice, but did not wish to be seen by GPs as "my" CPN in the same way as they saw GPs having "my" district nurse or "my" health visitor. This possibility also appeared to be seen as a threat to the CPNs' professional identity. The CPNs believe that some GPs see CPNs as "partners" or "sources of expertise" who can advise on mental health problems for which they believe GPs are not well trained, and would like to develop this role with all GPs. At the same time the CPNs acknowledged that it is important to their status and standing to win GPs' confidence and that such confidence is not automatically awarded by the GP but has to be won and fostered by the CPN both through the quality of their work and by having a presence at the surgery.

When comparing social workers with CPNs, Sheppard (1992) found that most of the contact with GPs was initiated by CPNs and that GPs seldom initiated the contact themselves once a referral had been made. CPNs were also more likely to give case-based information to the GP than social workers, although GPs were more likely to attempt to influence a social worker's case work than a CPN's. The South Durham CPNs believed that it is appropriate, and necessary for reasons of legal protection and "professionalism", to pass regular written information about their initial assessment, progress of the client and the outcome to the GP. The CPNs were not specifically asked to make any comparisons with GPs attitudes to social workers, nor did they spontaneously offer any significant comment about the relationship with social workers and GPs. However, the CPNs had strong views that the special status of the GP as RMO made it obligatory for the CPN to be "professional" and keep the GP informed, whether the GP was interested or not. They also believe that in some cases the GP's lack of knowledge of mental health problems means that the CPN should bring the

details of each case to the GP's attention, if only to "cover their backs" in case of an enquiry or litigation.

Prior's work, (1993), on the social construction of mental illness, also links with my findings. One issue is that of the "mental-illness-medical model" of doctors and the "mental-health-problem-psycho-social-model" link made by other caring professionals, which Prior suggests are derived from *"the sum of the practices surrounding it* (the idea of mental illness)*"* (p77). His argument is that the perception of mental health problems is linked to the explanations of causality underlying the thinking of each professional group involved. Most of the CPNs in my study made a distinction between types of mental illness needing admission to hospital, linked to the need for the involvement of a psychiatrist, versus reactive mental health problems which did not need a psychiatrist's involvement and which could be treated in the community.

The theme of struggles to create a professional identity, and the lack of specialist formal training as a CPN, appear to be strongly linked to the apparent lack of a coherent theory of CPN practice and the paucity of research on the effectiveness of CPN practice. Psychiatric nurses in the hospital are seen as suffering role confusion between being "carers" and therapists (Gijbels & Burnard, 1995) with their nursing resting on theories borrowed from other disciplines - medicine, psychology, sociology. This observation suggests that when nurses move to the community as CPNs they are not moving away from nursing with a well defined theory to working with a more diffuse theory. If anything they are moving into an environment which is likely to increase the "role confusion" because of the wider range of problems referred to them in a therapeutic environment which has a less specialised focus – mental health problems are only one type of problem in the primary care world.

However, whilst many of the CPNs in the study were aware that the theories underpinning their work were borrowed, this was seen as a positive way of broadening what was seen as the dead hand of the medical model of care for people with mental health problems. However, they also felt the lack of any single, or integrated, theory of community psychiatric nursing denied them any

valid means of rigorously evaluating their therapeutic work. The carer/therapist tension appeared to be a significant one for the CPNs, related to the lack of a clear remit, in terms of their professional identity.

Pollock (in Brooker & White, 1993) suggested that community based care is usually seen as the best and most humane way of treating mental disorder wherever possible. The general view is that community care is "good" and hospital care is "undesirable" except for people who are at risk of harming themselves or others. Prior, (1993) states that this is not necessarily a valid opposition and the concept that the community itself can be seen as an institution was not always apparent in the CPN culture he studied. Some South Durham CPNs were aware that living in the community was not always ideal, and could be on occasions detrimental to patients especially those who had spent years in hospital on a long stay ward. The CPNs in my study did not have strong views that CPNs could, or should, try to change the community although seven or eight of them had the view that CPNs should actively promote the view that the community should be "taught" to accept ex-patients and not be afraid of them. The continuing existence of stigma about mental health problems, and stereotyped images of violence associated with mental illness, were seen as targets for change but this was not seen as necessarily within the CPN remit. The main emphasis was the on providing "holistic" care for patients/clients, and their carers, as a means of helping them coping with the pressures of living in the community.

What my work contributes to the literature is how all the above findings interact in the culture of CPNs in the study. All the main elements of the culture are individually in the literature but have not, until now, been shown to be simultaneously present in the culture of a particular group of CPNs. Such themes as the nature of relationships with medical staff, lack of definition of the CPN role, the "tug" between working with severe and enduring mental disorder versus psycho-social mental health problems and problems of professional identity have all been noted in previous work. A comparison of the results of my fieldwork and the literature, show that many of the features found in the South Durham CPN culture do not exist in isolation but are representative of CPN views and

values found elsewhere. Given that the CPNs work for a large, and complex, organisation, the NHS, which has central policies and aims, it would be surprising if the South Durham CPN culture did contain only locally generated views. The CPN culture is subject to external influences such as GP referral patterns which do contain some local variations but the GPs themselves are also influenced by the same central policies as the CPNs. Overall it seems that all workers in health care are involved in an intricate web of pressures and policies, interpreted at a variety of level and detail, which ultimately derive from centrally defined policies. Local interpretation of central policies may not translate into identical specific views and actions at the working interface between clinician and client but would be expected to create similar cultures in groups with particular tasks and areas of concern.

Wider issues contributing to the debate over the future of community psychiatric nursing services, arising from the research.

Themes such as relationships with other professions within the NHS and with workers in outside agencies, particularly social workers, the lack of a detailed formal remit, in terms of referral and treatment protocols, and the lack of a clear future pathway all pointed to issues about establishing and maintaining a stable professional identity.

Given the continuing emphasis (in 2002, at the time of writing) on community based care and the process of merging social and health elements of caring for people in the community, the final considerations in the discussion of the work appear to be:

- how do the findings relate to the future development of community care for people with mental health problems?

- how far are the CPNs maintaining an institution in the community through interaction between their culture and policy initiatives such as the Care Programme Approach which monitors people who may be a risk to themselves or others?

- what do the themes say about CPNs' view of their role in the future? Is there a set of issues for CPNs at a national level which could be/should be addressed in the current debate on the future direction of mental health services (National Service Frameworks, the roll-out of the National Plan, a new Mental Health Act to replace the 1983 Act?)

The CPNs are strongly committed to the value of caring for people in the community. This value exists although most CPNs understood "community" to mean a wide variety of things, most of them not well defined. The definitions ranged from the common "community means not in hospital" to "living in the everyday world". In some cases this was also coupled with a view about the hospital away taking one's responsibility for one's own mental health and daily living, with "living" in the community seen as not absolving people from taking this responsibility.

The value of community-based care is almost an axiom for the South Durham CPNs, but does not appear to be based on formal evidence that community care is best for the client, nor that it works, but appears to arise from a mixture of being influenced by policy directives, dislike of the alternatives, such as hospital based care, and reasoning from the common-sense proposition that in the majority of cases living at home with whatever social networks exist is better than being on a ward. Some of the CPNs had a view that the community could be an institution for people who do not, or cannot, function as autonomous human beings because of mental disorders. In spite of such reservations community was still generally thought preferable even for those who may be a risk to themselves or others: the community, i.e. the general public, was seen as needing to accept some risks in order to avoid locking up sufferers unnecessarily.

Another feature of community based care is the increased range of presenting or referred problems for which the CPNs had little training or hospital based experience. This has implications for better universal training, perhaps in the same way as health visitors, midwives and district nurses take formally defined and recognised qualifications before being allowed to practice in the community.

The need for extra training, however, raises the issue of having a well defined remit for which a training syllabus can be developed. CPNs believe that in their work the social and health elements of care are blurred and that their work often shades into social counselling rather than health care. Many of them believe that this is an artefact of the separation of health and social care into different agencies which creates the view that the social and health elements of the patient's problems are also separate, and can be treated separately, when this may not be the case. Policy at the time of writing (2002) in the National Plan seeks to move quickly to merge social and health care which may remove the problem for CPNs by channelling clients through a single assessment to the most appropriate service – it may also exacerbate the problems if merged services do not offer a full range of services to meet expressed and assessed needs. For example, if clients are seen as needing social care rather than health care, there has to be sufficient social care capacity to undertake work that previously may have gone to CPNs.

Many of the CPNs acknowledge that the issues of training, the increasing prominence of primary care as the driving force of the NHS, and the possibility of changes in the remit of social and health care workers, will cause the role of the CPN to change. If training becomes mandatory, and the content of courses is tailored to reflect other changes in the structure of community based services, some of the CPNs felt that they could achieve a more secure "practitioner" status. Two main directions are seen by the CPNs as possibilities: a return to concentrating on mental illness, moving nearer to consultant psychiatrists, or a further widening of the CPN role in primary care probably as part of a primary care practice team. Very few CPNs believe that they are currently in anything but a transitional stage and there will be much more change to come. The perceived likelihood of change is seen by them as contributing to the role conflict apparent in their minds and with the threats to their identity and for these reasons some resolution of the training and remit problems would be welcome.

Whichever way the CPN service develops the CPNs support the development of having specialist nurse or nurse practitioner status, as part of the need to remove some of the insecurities about their professional identity. There is a view that

they are already acting in one or both of these roles, *de facto*, with the exception of nurse prescribing. Even if social service departments take over as the lead agency in caring for people with chronic and enduring mental disorders, the CPNs see their nurse training as a critical element in maintaining the client's stability by monitoring medication compliance and observing signs of potential relapse for which they believe social workers are not trained. They believe that developments in this direction would need careful consideration to be given to the respective roles of social and health care workers particularly when referrals come from GPs who do not have specialised training in the diagnosis/assessment of mental health needs.

During the period when data were being collected the Care Programme Approach (CPA) was just being implemented (DoH, 1990) and the Supervision Register (DoH, 1994) was also being developed. The CPA means that all people who are referred to the Trust with a mental disorder, either as inpatients or non-inpatients, have a nominated key worker, usually a CPN, who is responsible for ensuring that there is a formal care plan for each person and that it is implemented. This procedure is intended to ensure that people are not ignored if they miss appointments and that more complex cases are regularly monitored for any signs of relapse or problems with medication. Concerning medication, CPNs were inclined to talk about "compliance" and "non-compliance" with the taking of prescribed drugs which suggests some element of "nursey" behaviour and thinking is still very present. The effects of CPA were perhaps still too recent for it to have made a noticeable impact on the CPN culture at the time of fieldwork, but it raises the issue of CPNs being "gatekeepers" not only to the hospital for people with severe problems but also of the CPNs being "gatekeepers" to "normal" life in the community by recommending the discharge of a client from CPA requirements. (Morall, 1999).

The Supervision Register was also relatively new and because there were only 10 people on it (in 1999), for a total catchment population of 276,000 people, had also not made a great impact on the CPNs' views at the time of the interviews. Where it was mentioned during data collection, it was with concerns about the legal consequences for a CPN if a person on the Register was to harm themselves

or others. It is possible to see the operation of the Register as possibly strengthening the "custodial" role of the CPN in the future by bringing some more of the "controlling" features of the hospital out into the community.

Generally, the implications of the findings about the CPN culture for the philosophy and practice of community care for their clients, are not particularly clear because the service appears to have been in a transitional state for some time before and at the time of fieldwork. The uncertainties generated by the changes appear to reflect in the views of the CPNs. For instance, this lack of clarity is expressed in the "tug" between caring for those with severe and enduring mental disorders and treating the "worried well". The CPNs themselves have views about this balance but also appear to feel that their views have been over-ridden by policy developments. At the time of fieldwork there was a range of developments and changes taking place; the closure of Winterton hospital, contracting and GP fund holding as well as the requirements of the Community Care Act, which gives social services a lead in the provision of continuing care in the community. All of these pressures can be seen as possible threats to the role of the CPN in community care and, through this, a threat to their professional identity.

Implications for the future developments of the CPN service.

The research raises some specific questions which help to focus the debate about the future of CPNs as providers of care. These issues are already matters of active debate but the research adds evidence that the issues shown below need to be addressed to ensure that the provision of a mental health service in the community is effective and meets the right needs of the population.

One of the main issues appears to be the training and development needs of CPNs. Until there is more clarity about the future remit of CPNs, and their role in both primary and secondary sectors, it is difficult to see how training and education can be changed from the present piecemeal system of development which has existed for some time (Barker, 1989, Brooker and White, 1990). The views of CPNs in my research suggests for many of them that the way in which

CPNs move to the community and learn their skills is not seen as satisfactory, but is currently the only route available to them Several people who had no initial CPN training felt that they would have benefited from the CPN Certificate course if they had taken it before moving to the community but that once experienced it would have little to offer. Those who had taken the course generally felt that it was not sufficiently detailed to meet all their needs but that it was helpful when faced with their first referrals. Whilst the many of the CPNs felt that their status would be made more secure if there was a mandatory qualifying course, they also thought that the content would have to change compared with the courses some of them had undertaken in the past, to include more practical training in psychosocial techniques.

The issue of CPN skills and education were not directly linked with the issue of professional identity, as the RMN qualification was seen as the major distinguishing feature between CPNs and the other disciplines involved in providing community mental health care. However, it seems that formal training as a CPN may become an issue in the light of pressure for more extended training in other disciplines such as social workers and psychologists who also work in mental health care in the community.

Another issue which is likely to become a high priority in the immediate future is the development of rigorous and accurate tools for evaluating the effectiveness of CPN care with the advent of performance management and health improvement initiatives (DoH, 1998,1999). There has been little evaluation of CPN practice to date (Gournay and Brooking in Brooker and White, 1995, Brooker et al, 1996) and additionally there is the associated issue of whether the targeting of services is effective (Repper and Perkins, Savio in Brooker and White, 1995). If CPNs are to maintain and develop their role as major providers of mental health care in the community, and in the primary care setting, it is essential that work is done to demonstrate that the cost of their service is justified in the competition for resources.

This issue was introduced in the research interviews as a question about "failure" - what judgements does a CPN make when a client does not make the progress

which is expected? In general, the answer was that "*CPNs do not have failures*"; either the client has not made the necessary efforts to "*get better*", has not "*done their homework*" and followed the care plan which was agreed between the CPN and client after the initial assessment, or the client is not suitable for treatment by the CPN and should see a different professional. The unspoken assumption was always that CPN "care" works for the majority of clients, that this answers the question about whether techniques are effective and that the causes of poor, or no, progress must lie elsewhere. It is suggested that this view will have to be challenged if the CPN service is to meet the challenges of performance management and clinical governance, as outcome measures of effectiveness begin to replace simple throughput figures..

All of the above issues have a bearing on the question of the future of CPN services: will CPNs continue to develop, perhaps as specialist or practitioner nurses, or will they disappear as a separate practitioner discipline, replaced by doctors and other professionals? There are a variety of views in the literature already cited and the CPNs' own views are equally as diverse. The view expressed by many of the CPNs in my study was that there are so many possible influences on the situation that it is not possible to see the way ahead with any clarity at all. The rapid policy changes of the 1990s, with new initiatives being introduced before their predecessors have become established or fully worked out (fund holding, contracting, PCGs and PCTs) were given as a major obstacle to planning the medium to long term future for CPN training, education and skill building. There are influences on both the clinical aspects of the CPNs' work as well as on their management and their place in the NHS structure. Until some stability is achieved in these areas it will not be possible to plan the future of the service.

The lack of clarity for the future, in terms of clinical contents of the work, role and status, was noted by the CPNs as contributing to the perceived stress of the job as well as over large case loads and a shortage of clerical support. They believe that whilst community psychiatric nursing handles the bulk of mental health work in South Durham it is the inpatient services which command the greatest attention. The South Durham CPNs' views on their situation were in

line with similar findings elsewhere (Fagging et al, 1995, Fielding and Weaver, 1994) which invites serious consideration of research intended to find ways of supporting a push for more resources, both clinical and administrative, dedicated to determining whether CPNs are effective both in terms of the successful treatment of mental health problems and being the most cost effective method of doing so.

At the time of writing, two years after doing the field work and as a consequence of new policy requirements (the change from GP fund holding to primary care groups, the publication of specific targets for improvements in mental health and local changes in management following a merger (DoH, 1999) the Trust is reviewing the referral procedures to CPN teams with a proposed move to consultant assessment of referrals to the teams before a CPN, or other discipline, begins to treat.

The research suggests that many of the issues raised by the literature remain unresolved in early 2002 but with the increasing emphasis on evidence based, research led practice (DoH, 1999, 2000) and a parallel increase in monitoring the quality of services (with the introduction of clinical governance and creation of the Commission for Health Improvement and the National Institute for Clinical Excellence) the position of the CPNs in the future could become increasingly untenable unless issues of formal certification and the use of well founded protocols for care are introduced.

Critique of the work.

The research overall went as planned without any major problems and provided information and insight into the cultural values of the CPNs working in South Durham in the middle 1990s. My conclusions were that their values reflect issues from the wider NHS as well as ideas which are specific to CPN practice. The influence of early training and experience on a psychiatric hospital ward was shown to have several effects and carried over into the community, but in a way which had not been anticipated.

"Hospital-type" nursing behaviour and values were found in the community associated with people who have chronic and enduring, usually psychotic, mental disorder. However, added to this was a new repertoire of care for more transient, and less intractable, problems such as reactive depression, which the CPNs had had to learn to treat once they left the hospital and began to work in the community. The hospital experience was not discarded or replaced but was modified and added to by later experience. I had not expected such a clear cut bifurcation but at the beginning of the work had anticipated that a nurse moving from the hospital would either completely take up the "community-style" counselling approach or simply maintain the "nurse in charge – patient doing as told" approach in relation to the whole range of her/his work..

A second unexpected finding was that for many CPNs their early nurse training was more progressive than the regime they found on the wards and this situation acted as a motivation to work in the community. This appeared to be the case even for some of the CPNs who had originally gone out and set up the service from scratch, several of whom were still practising and were included in the respondent group.

Looking at the details of the work; the early design and formulation of the questions had taken place over a long period, from 1987, when I had done some work with the CPNs in South West Durham. Between that time, and beginning field work in 1996, I had continued my association with them, because of my everyday work on information collection and analysis for the Trust, which helped to refine the research questions. The Chief Executive, Director of Finance (who was at that time my line manager) and the Director of Operations were all supportive of the proposed work and authorised access to the field and the use of my time, and the CPNs, to do the work.

Familiarity with the CPNs helped me, to some extent, to enter the field without too much difficulty and recruit respondents for the project. However, perhaps because of my senior management status, and association with the management of South West Durham Trust it proved difficult to recruit all the CPNs from the South of the county following a merger with South Durham Health Care which

took place after the beginning of the project and immediately before the start of fieldwork. I was not known to this group of CPNs and 6 of them were reluctant to take part in the project although the reasons were not explored.

Fieldwork was complex to manage because the CPNs had full case loads and diaries booked up weeks in advance. Being employed by the Trust facilitated my attendance at each community team's monthly meeting to present my ideas and to ask for the CPNs' participation, as well as to book times and places with them. Being allowed to use interview rooms on the Trust premises allowed me to maintain the confidentiality promised as a condition of taking part in an interview. A second minor difficulty was managing tape recording and detailed note-taking as well as listening to respondents during interviews. After two pilot interviews the interview schedule and note-taking sheets were preformatted to ensure that respondent codes were entered before interviews and that there was a set of prompts for myself to follow up on any new material introduced by respondents.

Detailed notes were taken for two reasons: in case of tape failure, which only happened partially twice, and because my hearing is damaged; during transcription of the pilot interviews it was found that the tape recorder picked up extraneous noise which was difficult to filter out when replaying the tape. The problem was overcome at the recording stage by using a table microphone at some distance from the tape unit, and at the replay stage, by using headphones and an improvised pause button attached to the computer key-board. The detailed notes were invaluable when isolated words or phrases on the tape were unintelligible.

The interview meetings were largely without problems. The interviewees, appeared to feel free to express their thoughts, in spite of the tape recorder. Being already personally known to more than half of the CPNs helped but even those who did not know me well appeared to have no problems in speaking. In most cases some initial encouragement was needed to start the conversation because in their normal practice CPNs ask questions and listen to the answers. Therefore, the research interviews were a reversal of their everyday role. In the

early interviews one person commented on this. In subsequent interviews I specifically raised this issue at the beginning of the meeting to try to put the respondents at ease.

Having sufficient material for interpretation was a concern during the design of the fieldwork but after undertaking the interviews the opposite proved to be a minor problem – collating and interpreting a large mass of rich and detailed material. Fortunately, many of the themes began to appear early in the fieldwork and were explored and refined during later interviews. Each interview was transcribed onto a computer word processor file as soon as possible after taking place – items of interest were marked and noted at that time. Once interviews were complete, the use of computer software, QSR-NUDIST, facilitated analysis and interpretation of the transcripts. The automatic search facilities were not used, the selection of material was always under my control, but the ability to use the software to group, collate and cross-reference the data made the process of analysis more systematic and orderly.

The task of writing the thesis itself was one of the most problematic because the work was done piecemeal, on a part time basis, and it proved difficult to maintain continuity of development when writing. A second distraction arose from the nature of my work for the Trust which, during the period of the project, involved me in several major pieces of work including two major service reviews of community based care. Maintaining a boundary between my private interests and job-related tasks was problematic and occasionally led to confusion about which material I was dealing with. For example, one large scale review of the type and volume of work done the community teams concerned the balance between chronic and enduring problems versus what is now called "common mental health problems" referred by GPs. The material from this particular review overlapped with some of the interview data about the CPNs' ideas in this area and an effort was needed to keep the two projects separate in my mind.

The final task is to consider ways in which the work could have been improved. One major issue was that the research raised more questions than it answered. It is difficult to see how many of these questions could have been built into the

work, given the time and resources available, without the data becoming unmanageably prolific. Some of the questions actually arose from the analysis and were not apparent at the time data was being collected and as it was a one stage collection it was not possible to revisit the interviewees for further more specific information. However, identifying the questions serves a useful purpose in that they supply a starting point and direction for future research to build on.

There are several questions which arose from the analysis of material gathered during fieldwork and which could not be fully answered during analysis. One question is about internal and external influences on the CPN culture: how far is it passive in terms of responding to the influence of external agencies and how far do internal factors make it self sustaining and robust? There was some evidence about the effect of external policy-driven changes but the extent of resistance to change, or not, was not explored.

Another question which became apparent is how far the CPN culture plays a part in changing or maintaining the social organisation of the definition, status, care of mental illness and mental health problems (cf Prior, 1993). This is linked to a question of how far are the CPNs legitimising psychiatry in the community and how far they are an influence for changes of attitude in society, medicine and other nursing specialties.

Two final questions were: how do CPNs differ in their concepts of what "nursing" is compared with other non-mental health nurses in the community and with other professions in mental health care such as social workers? There was some material about the CPNs' views on the role of social workers in mental health care but the issue of CPNs versus other disciplines/professions in the community was not explored sufficiently to show any useful detail.

Another issue is that of possible improvements in my research method and the design. A second round of interviews or focus groups would have allowed me to saturate and clarify the details of themes found in the analysis of first round of interviews by feeding the interpretations back to the CPNs and listening to their

reaction. This procedure would possibly have produced more detail and allowed further possible links between themes to emerge more clearly.

A second improvement would have been to have included CPNs from different areas to explore the culture for local versus general views. This wider design could have also used several methods to triangulate material from diverse sources - use of other types of data source: research diaries, written reports from CPNs in other areas.

Most of the potential improvements noted above would have required more time and resources than was available to me for the research and therefore represent to some extent a "wish" list or a counsel of perfection but, nevertheless, it is felt that they should be outlined as they were considered during the design and execution of the research.

Reflections on the research

The act of writing a thesis forced me to refine my thoughts and ideas and revealed that in the early stages of the work, and during the data collection and analysis, I was working with a less than precise idea of what I wanted to achieve. A mass of ideas was generated and many insights were present but did not fully develop into a coherent framework until I began to write the thesis. The earlier stages were characterised by an understanding that was as much intuitive as it was explicit and systematic. I also became aware of two personal attributes which were less than helpful. One was that I am a divergent thinker and can be drawn down side paths by interesting associations and corollaries of the main theme. The other was a dislike of isolating any phenomenon in the social world from its context although it is fully accepted that in all research "*the reality always escapes the data*" (Silverman, 1993), in the sense that any description, qualitative or quantitative, of a situation is an abstraction which cannot reproduce the whole of the reality.

A major response to writing the thesis is that the research would have been less exploratory and more focused if the thesis-generated insights had been achieved

at a much earlier stage although there was also a counter balancing thought that by remaining in the "intuitive" phase for most of the work facilitated the analysis and interpretation - *verstehen* - of the data.

Hindsight suggests that I would have had less problems controlling and formalising a mass of ideas and thoughts if the earlier stages of the work had been less wide ranging and more focused. My chosen technique of reading and thinking widely in the area of my research was intended to avoid coming to the analysis with a relatively small number of fixed and static ideas. I hoped to work in a state where I was aware of a wide range of ideas which were not necessarily part of a consistent and thought-through framework. The unintended effect was that having done my research against this background it was very difficult to select and structure the mass of material, from literature and interviews, with which I had presented myself when writing the thesis. In balancing the risk of introducing my own preconceptions I had not balanced the problems of the need to be systematic and structured when presenting the product of the research.

If the process of developing a sense of self-awareness and self questioning, as a researcher, is one of the educational purposes of a research degree then I appear to have benefited at least in this aspect of the work.

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APPENDIX 1: Mental Health Legislation during the 20th Century

The 1983 Mental Health Act is the current legislation dealing with involuntary admission to hospital; it deals with the reasons for such an admission, the procedures which must be followed to validate the use of the powers, the safeguards for patients and the appeals procedures against the application of the Act. It also defines the responsibilities of those using the Act towards a detained patient. Whilst it does not apply to all mental health patients it is a central influence in the whole culture of mental health care and the perception of mental disorder in society.

The 1983 Act superseded the 1959 Mental Health Act which was based on the findings of the Percy Commission. The 1959 Mental Health Act was hailed at the time of its introduction as "*the most humane and imaginative piece of legislation enacted this century in relation to the mentally ill anywhere in the world*" (Roth & Bluglass, 1985). In its turn the 1959 Act had replaced a large group of older Acts, or sections of Acts, some going back as far as the early 18th century. These older Acts have to be considered in the light of the social conditions, norms and beliefs of their time; if this is done they are less punitive or repressive than one may think and they represent an attempt at humane treatment even if this does not instantly strike the modern reader.

The situation in other countries is more problematic in that the detention of people in psychiatric hospitals is more bound up with criminality and the fitness of a person to be held accountable for their actions (Roth & Bluglass, 1985). America is the place of most interest in this respect as it has both nationally applicable federal laws as well as locally applicable state laws; it has also been the locus of much influential research into mental illness such as Goffman (1958). Some of the early application of community based care was also carried out in the United States and this has influenced the law.

Structure of the Act.

The structure of the Act is slightly confusing for anyone approaching it for the first time. It is in 10 parts which contain a total of 149 sections. Each part deals with a major topic:

I. Application of Act
II. Compulsory admission to hospital,
III. Patients concerned in criminal proceedings or under sentence and consent to treatment,
IV. Consent to treatment,
V. Mental health review tribunals,
VI. Removal and return of patients within United Kingdom etc.,
VII. Miscellaneous functions of Local Authorities and the Secretary of State,
VIII. Offences,
IX. Miscellaneous and supplementary

Within each part the Sections deal with such things as definitions of patients, staff approved to use the act and the powers they have as well as the limits of the powers, appeals procedures, notification of nearest relatives and the duties and responsibilities of those invoking the Act. (In addition, there are six acts which constitute 'delegated legislation' and a series of DHSS Circulars offering guidance, an approved Manual with illustrative case law and a mandatory Code of Practice.) Taken together this is a formidable body of law which has to be thoroughly understood by those who use and administer the Act.

The broad provisions of the Act define:

a. who can be detained and why,
b. holding powers until assessment can take place,

c. detention for assessment,
d. detention for treatment.
e. detention under guardianship

The definition of who can be detained and why,

Part 1, Section 1, Subsection (2) of the Act defines "mental disorder" as meaning *"... mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of mind".*

(There is no age lower limit - the Act applies to children as well as adults although the Manual and Code of Practice offer a great deal of advice and guidance for the application of the Act to legal minors.)

The Act then goes on to define these terms in more detail but without reference to any clinical diagnostic classification such as ICD9, ICD10 or DSM-III. The specific categories under which a person may be detained are:

1. mental disorder (which includes mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind)

2. severe mental impairment (arrested or incomplete development of mind which includes severe impairment of intelligence or social functioning and is associated with abnormally aggressive or seriously irresponsible conduct)

3. mental impairment (a state not amounting to severe mental impairment but having the same features at a significant level)

4. psychopathic disorder (a persistent disorder or disability associated with abnormally aggressive or seriously irresponsible conduct but not necessarily including impairment of intelligence).

A person **must** be classified into one of these categories before the Act can be invoked. The Manual notes that these definitions are not medical terms but have their common sense meanings and reference should also be made to case law (quoted in the Manual). Further definitions are issued by the DHSS in a Consultative Document which offers more commonsense descriptions of the manifest symptoms by which a person can be judged to fall into one of the above categories.

There is one interesting exclusion clause in the definition which states that "... *nothing in subsection (2) above shall be construed as implying that a person may be dealt with under this Act as suffering from any form of mental disorder ... by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs*". As noted in a previous section this means that whilst a person may be referred to a psychiatrist for psychiatric problems related to alcohol dependence, the alcohol problem is not sufficient to permit detention under the Act. This also removes possible abuse of the Act for detaining a person for moral deviance which may have happened in the past.

Another feature of the Act is the insistence on complete documentation of each stage of a person's detention - if this is not done the person is then detained illegally and can walk out of the hospital at will as well as having the right to seek redress via damages under the civil law. The Act defines the precise information that must be collected, from whom it must be collected, when it must be collected and the time limits for doing so as well as who must sign the forms to authorise detention. It also specifies the forms on which the information must be recorded, to whom they must be sent and when. A separate body, the Mental Health Act Commissioners, who are empowered to act as patient advocates, pay particular attention to the correctness, and therefore legality, of the documentation during their visits to a mental hospital.

Holding powers until assessment can take place.

There are basically two situations in which the Act allows a person to be temporarily detained; by hospital staff when the person is already in hospital as an informal patient (both nurses or doctors can hold a patient but under different conditions) and by the police when they feel someone is a risk to themselves or others.

The holding powers allowed to hospital staff are intended for use in a situation where an informal patient suffers a change in their condition and become a risk to themselves, particularly suicide, or become a threat to others and threaten to leave the hospital.

Section 5(2) allows a doctor to hold a person, who is already an informal patient, for 72 hours for assessment, with several possible outcomes. It is not used to admit a person to hospital from the outside. If, after assessment, the person is thought to need further assessment or require treatment and needs detaining under the Act for this to be carried out they must be detained, as soon as possible, under the appropriate Section. Otherwise they must be discharged from the Section (but not necessarily from hospital) as soon as it becomes apparent that they can revert to being an informal patient. The Section is not renewable although it can be used more than once in any single episode of care if a period of treatment as an informal patient intervenes. The doctor applying Section 5(2) can be a Consultant or one nominated junior doctor who has sufficient experience to enable her/him to make the required judgements.

For nurses Section 5(4) allows them to hold a patient for up to 6 hours in the absence of a doctor. The Section lapses at the moment an appropriately qualified doctor arrives on the scene. The use of this Section must be fully and immediately documented and the Act requires scrutiny of each occasion it is used. It is only intended for emergencies where a doctor is not present and may not be for a time because of events elsewhere. After 5 hours the nurse must contact one of the Hospital Managers (one of a group of senior people designated

to have specific responsibilities under the Act) who is required to supervise the patient's departure. If a doctor does not attend within the 6 hours the Managers are required to hold an enquiry and can expect censure from higher authority in the NHS unless there are extremely compelling extenuating circumstances.

Under section 136 the police have the power to remove a person from a public place to a place of safety if they are mentally disordered and in need of care or control - the usual definition of being a risk to oneself or others is again the guide. The place of safety is normally a police station and the person concerned is regarded as being in custody during this time. (The case law in the manual suggests the Act does not approve of police stations being used a places of safety but it is allowed in Section 137(5) and this is local practice.) The Act allows the police to detain some-one for up to 72 hours but also requires that the person detained should be seen by an Approved Social Worker (ASW) and an approved doctor with the minimum possible delay. This section of the Act places great emphasis on co-ordinated procedures and practices between the NHS, Local Authority and the police to get medical help as quickly as possible to people held in a place of safety.

If an ASW has reason to suspect that a mentally disordered person is present on any premises and is at risk (including neglect of such a person by others) or is a risk they may apply to a court for a warrant under Section 137(1) to allow the police enter, forcibly if necessary, and to remove the mentally disordered person to a place of safety where the conditions and procedures for Section 136 then apply.

Detention for assessment and detention for treatment.

There are separate provisions made for admitting people to hospital for assessment. These fall into three categories: ordinary members of the public, people on remand for criminal offences and people convicted of criminal offences. For the last two categories there are also restrictions that can be placed on movement and only changed by a court or the Home Office.

There are several Sections for admitting people, not on remand or in prison, to hospital. If the person's problem is not clear or cannot be diagnosed without hospital admission they can be admitted for assessment under Section 2 if they are a risk to themselves or others. This allows 28 days for the patient to be assessed and then discharged from the Section and from hospital, to be discharged from the Section and treated as informal patient or to be transferred to Section 3 for treatment as they remain a risk. It is illegal to renew Section 2 at the end of 28 days - the patient must either revert to informal status or be detained under Section 3 if there are doubts. If the patient is found not to need treatment at any time during the 28 days they must immediately be discharged from the Section and from hospital.

For both of these sections the phrase "at risk of harm" can be taken to mean at risk of emotional as well as physical harm but does not include the patient being violent to property only to other people.

An application for detaining a person under these sections can be made by an ASW or the patient's nearest relative. If the ASW begins the application and the nearest relative objects the application cannot proceed. In both cases the written recommendation of two approved doctors, one of whom be familiar with the case, must be provided to the hospital managers before detention under the Sections can take place.

Another Section which relevant in this part of the paper is that dealing with consent to treatment of detained patients. Common law governs consent to treatment even for detained patients except where the Act specifically overrides it. (Code of Practice, 1990) The general principle is that in life threatening emergencies treatment can be given without seeking permission but in other cases consent must be sought otherwise the giving of treatment can become common assault. As mentally disordered people may be judged as not being capable of a rational decision particularly when refusing treatment the Act makes special and detailed provision for treatment without consent (Part IV). It is an ethically difficult area when injection of sedative drugs under physical duress or

the giving of electro-convulsive therapy (ECT) are under consideration. The use of both treatments even with consent are contentious matters for the professionals concerned - the issue of consent is an additional controversy.

Detention under guardianship

The Act also allows the courts to give Local Authorities the power of guardian, under Section 7, over a person not thought to be capable of managing their own affairs because of a mental disorder. The Code of Practice requires that this must be considered as an alternative to admission to hospital, to an acute ward and to continuing care facilities.

This does not involve the NHS and is not therefore relevant to an examination of the influences on the hospital culture. However, in the future it may become significant as the role of Local Authorities in providing continuing care grows.

Patient safeguards and potential for abuse of the Act.

The Act goes to great lengths, and into great detail, to ensure that detained patients' rights of appeal, consent to treatment and rights to civilised and humane treatment are respected. It is particularly in this respect that it was hailed as a great step forward (Roth & Bluglass 1983) when compared with earlier legislation which concentrated to a greater extent on the conditions of committal and the circumstances of detention (Grieg et al, 1915).

There are several safeguards to prevent a person being wrongly detained in a mental hospital and to prevent any initially justified detention from continuing for an unreasonable time. There are several groups of people who are charged with the responsibility for overseeing the operation of the Act: Hospital Managers, Review Tribunals, the Mental Health Act Commission and the Home Secretary. There are specified time limits which must be observed for acting on a an appeal to one of these bodies.

Another important body to which patients can make complaint is the Mental Health Act Commission. Like members of the Tribunal, Commissioners are people with knowledge of the professional law or mental health care and are empowered under the Act. This body is charged with overseeing the operation of the Act and operates in two main ways to ensure that patients' rights are observed correctly; patients can complain directly to the Commission if they feel they are not being correctly treated and the Commission itself has a program of visits to all the mental hospitals in the country when all aspects of the Act are audited. During a visit anyone, patient or staff, can ask to talk to the Commissioners about the care and treatment of patients. Their findings are published at the time of a visit and the hospital receiving a visit and report is obliged to act on the findings if there are any problems. If a patient makes a direct complaint to the Commission it will send one or more Commissioners to the hospital where they conduct an enquiry into the complaint.

The Commission publishes a series of biennial reports to Parliament which summarise its activities for the period; general issues are presented and discussed as are areas of difficulty in things like interpretation of the Act. The reports' main functions are to highlight examples of good practice in order to make them known to all concerned with operation and administration of the Act.

A similar body is the Lord Chancellor's Visitors (generally Part VII and specifically Section 102,103) who deal with cases where control of a patient's financial and business affairs is given to the hospital or Local Authority under guardianship or Court of Protection orders.

Comparison with committal in the past.

It is salutary to remember that the 1959 Mental Health Act was the most substantial piece of legislation in this area since the early part of the century. (Roth & Bluglass, 1985). It is even more startling to reflect that it was only 11 years after the mental hospitals had been transferred from Local Authority jurisdiction into the newly founded National Health Service. At that time the

older acts were still in force (as found in Archbold, 1915) and this was the case until 1959. There was a bewildering variety of laws governing mental disorder in which had changed little since a commentary of the late 19th Century (Wood Renton, 19898) which suggests that the same body of law operated over some decades prior to 1915.

Archbold (1915) quotes 13 major acts dealing with mental disorder (the term used then was "lunacy") and 208 pieces of associated legislation some of which went back to 1714; for example some Acts deal with things like poverty but include provisions for lunacy when associated with poverty. In comparison, the 1983 Act has 6 associated pieces of legislation and repeals, revokes or consolidates all or part of 29 other Acts.

Mental deficiency and defectives (sic) are included; at this time they seem to have been associated with mental disorder, perhaps because both conditions were seen as inimical to normal social functioning. An examination of the admission registers at Winterton shows a large number of people were admitted for "imbecility" and occasionally as "defectives"; in practice the distinction between perceived lunacy and mental deficiency seems to have been ignored for the convenience of treating both in the same establishment.

Quite a lot of the 1915 legislation deals with paying for care in the mental hospitals of the day; both public and private hospitals and asylums were in existence. The emphasis on financial matters may initially be distasteful to modern readers but the welfare state is a relatively recent phenomenon and before it existed the need to pay for services was an important matter. There were some social provisions for those in poverty but these were minimal and the concept of paying for many of the things we expect to come from the public purse, locally or nationally, did not exist in the recent past.

The Acts of 1890 to 1911 are discussed by in Archbold (Greig, 1915)as though they were supplementary to each other and not successive re-enactments. These Acts have six major parts dealing with:

I. the Board of Control,
II. Institutions for Lunatics,
III. Reception Orders,
IV. Care and Treatment and Visitation,
V. Expenses of Chargeable Lunatics,
VI. Lunacy Regulations.

The members of the Board of Control consisted of no more than 15 Commissioners of whom twelve had to be paid; four were to be lawyers, four were to be medical practitioners - the qualifications for the remainder were not specified. Interestingly, the Act also specified that at least two Commissioners were to be women and at least one of them was to be a paid Commissioner. The Legal members were appointed on the recommendation of the Lord Chancellor and the others by the Secretary of State. The creation of Commissioners was not new to this legislation as it then goes on to deal with the transfer of tenure for Commissioners appointed under older Acts. The reasons for requiring the appointment of some female Commissioners is not given nor do subsequent parts of the Act give them specific duties because of, or on behalf of, their gender. This remains slightly anomalous as women did not then have the vote and there appears to have been resistance to their active participation in professional and political life although there was an active women's' movement campaigning for these things. (The vote for women over thirty was enacted at this time - 1915 - but full equality of franchise with men was not achieved until 1928. Admission to Oxford was only achieved in 1920 with Cambridge refusing them admission at that time.) There are several ways to interpret the existence of women Commissioners: a sop to pressure from the women's' movement, reluctant recognition that they were gaining power?

The duties of Commissioners were to oversee the licensing of private premises for use as places of residence for "lunatics", visiting all places where mentally disturbed people were living to ensure that the institutions were properly administered and run, and to advise on the committal of people to these institutions. (The following section on Institutions shows that the Commissioners acted only in the area around London and that their functions

were largely exercised by Justices of the Peace in other areas - for some reason Lancashire has its own regulations based on a specific Act of Parliament. This suggests that there was a perceived north/south split at that time - perhaps the difference between commerce and trade in the south and heavy industry in the north.) In areas where a Justice acted instead of a Commissioner there was a requirement to appoint a further three Justices to act as "Visitors" who discharged the inspection functions on behalf of the Commissioners. One of these was to be a qualified medical practitioner who was entitled to a fee for the work. People were debarred from becoming visitors if they had any financial connection with a licensed house or hospital.

People in any one of these institutions appear largely to have been committed rather entering voluntarily. For example, an inspection of the early patient admission registers at Winterton shows that there were very few private voluntary patients in the 19th and early 20th century.

Like today, there appear to be several routes by which a person could enter one of these institutions but the Act itself distinguishes two ways which were of significance in the society of 1918; orders concerning private patients and orders concerning paupers. (A private patient was one who was not a pauper or a criminal lunatic, presumably some-one who could pay for their stay in the institution.) These were called reception orders in the Act and are revealing in that they are orders to an institution to "receive" and hold a person judged to be a lunatic rather than a straightforward removal of liberty from an individual. The order was a consequence of a person having already been judged to be a lunatic and was not made in order to establish the condition. There appears to have been the assumption that once so judged, the need for custody was imperative.

One could be committed under an "urgency order" - this needed a statement of particulars from some-one who knew the disturbed person and a medical certificate. The person initiating the order was ideally husband, wife or near relative of the sufferer. The order was only to be made for the welfare of the person or for public safety and, in a phrase echoed in the 1983 Act not "for the

matter of temporary convenience". An urgency order only lasted for 8 days or until a judicial order was made if this was pending.

The other way in which a person could be committed was by judicial order which needed a statement of particulars from some-one who knew the disturbed person and two medical certificates, one from the person's own practitioner. As in the urgency order the petitioner should ideally have been husband, wife or near relative of the sufferer. The Act goes into great detail about the documentation of proceeding leading to committal orders and spends much time excluding those with vested interests from involvement in orders and petitions. (Here, the Act reads as though it is responding to unscrupulous practices by owners of licensed houses, or hospitals, to "drum up trade" for their own financial advantage.) The judge making the order was required to follow an extensive set of procedures to satisfy himself that the order needed to be made and once it had been made it had to be executed within seven days or it would lapse.

The order made in response to a petition was to last for a year in the first instance but the private detained person had the right to a separate judicial review in the first week of detention. The detention could be renewed if the person was still deemed to be suffering from their disorder.

For paupers or those who could be considered paupers because they were not under proper care and control or were being neglected or cruelly treated, there was a "summary reception order". This appears to have differed from a petition mainly in the person who initiated it. For a summary order this was a constable, relieving officer or an overseer. Presumably the relieving officer was concerned with the entitlement to, and distribution of, poor relief and the overseer, presumably of the workhouse, was concerned with parishes where there was no relieving officer. Any medical officer of a parish or union of parishes was to involve the relieving officer or overseer when an apparent lunatic was brought to his attention; this included the workhouse. Persons wandering at large within the district, whether pauper or not, who were thought to be lunatics were to be apprehended by the constable and brought to the attention of the relieving officer or overseer.

The Care and Treatment section of the Act deals with the physical treatment of the detainee and care for their physical health - there is perhaps little to be said about treatment for their disturbance as psychiatry was in its infancy. The regulations in this section are detailed and comprehensive ranging from diet to the treatment of female defectives - anyone taking sexual advantage of a female detainee could face penalties up to two years of hard labour. The use of restraints is to be carefully regulated and documented and only approved means are to be used. (The image of the straight jacket remains current in the popular image of mental disorder, as does "the men in white coats" a phrase used by one senior Labour politician of the Prime Minister in a comment to the Press on 28/12/94. Today the violent patient will be subdued by means nursing staff using approved hold-down techniques and then sedated.) Patient's rights to visits by friends and family, to letters and to review of their by Commissioners or Justices are also specified.

The things to be considered by Commissioners or Justices when making an inspection are laid out; most of the items are those which would occupy today's Commissioners in the same circumstances although they would probably not make Divine Services their first item as the Acts of 1898-1911 do; the Commissioners are asked to enquire when Divine service is performed, to what number of patients and with what effect. (It must be remembered that there was a strong movement to giving patients peace, quiet, fresh air and wholesome occupations, at this time, as a way of ameliorating their disorder. Presumably church attendance fell into that category. Older members of nursing staff claim to remember attendance Sunday services being compulsory in the 1950s with lines of patients being marched over to the church which is one of the earliest buildings on the site and occupies a prominent position.)

All the rules and regulations applied to lunatics in small establishments, with private families, in the workhouse and in charitable institutions as well in the larger institutions.

The fifth section of the Act is entirely devoted to the Expenses of Chargeable Lunatics and deals with the complications of charging and recharging between the various layers of local authority for the costs of dealing with pauper lunatics.

The final section shows the details of the duties incumbent on all the officials involved in administering the Act from the Lord Chancellor downwards.

Comparison between the MHA 1983 and Lunacy Laws of 1915.

When the MHA is compared with older laws it can be seen that in spite of the shortcoming outlined above it was a great improvement. There are some potential pitfalls to be made explicit when making this comparison, particularly the social and medical context in which the laws operated. At the beginning of the century the welfare state as we know it did not exist which is why much of the earlier legislation was concerned with how a person's care was to be funded - there was no immediate entitlement to care from taxes and the public purse, this would only happen if the person needing care was without resources. The legislation on poverty and the concept of the deserving poor should also be kept in mind.

The influence of eminent Victorian scholars on social attitudes is critical - Spencer and Social Darwinism, and the work of Galton on intelligence all contributed to this picture of people who deserved to be poor because that was all they were capable of. In such a milieu it would not be difficult to see the mentally disordered as a parallel case. This is not to suggest that the laws of that time are inhumane, they may be patronising but are an attempt to improve the lot of many people who would otherwise be victims of their problems. Unlike today the early asylums did not appear to distinguish between mental disorder, learning difficulties and those handicapped with by brain damage. (Given the state of obstetrics, midwifery and the conditions under which birth took place one can anticipate more people with brain damage from anoxia, rubella and toxaemia than we have today.)

An examination of the Winterton Registers of Admissions for the period 1858 onwards shows little change in the labelling and composition of the patient population until well into the 20th Century: there is a relatively small number of diagnostic categories of which "imbecile", "idiot" and "defective" all occur in conjunction with the more familiar dementia, melancholia and manias. Surprisingly, many were discharged as "cured" and there was already recognition of post-puerperal depression. There are records of people being transferred to other hospitals, at some distance, although without an extensive search of the records it is not possible to know why. Until 1948 the admission records always contains the name of the authority to whom the patients' care is to be charged which would be expected in view of the emphasis on funding found in the earlier laws. This is not to be dismissive of the laws; the concern with money is at the basis of ensuring that care is provided for all.

Equally, it is not necessarily a flaw in the early laws that they are mainly about finance and custody; medicine had little to offer the sufferer from a mental disorder and much of the impetus to care for them had come from social reformers and philanthropists. The main turning point for medicine came about in the early 1940s with the introduction of electro convulsive therapy for depression and then in the 1950s with the first introduction of effective anti-psychotic drugs and tranquillisers (Carlsen, 1977). Previously there had been some drugs which were used but these were weak and patchy in their effects when compared with the new compounds. (Even today, there are some people with psychoses who are unresponsive to treatment and the search for effective drugs goes on with things like Clorazil.) It can be argued that this was part of the motivation to recast the laws about mental health; to say less about custody *per se* and more about treatment. This happened in two stages; the MHA 1959 which fairly quickly gave way to the MHA 1983. Interestingly, while the availability and effectiveness of treatments for specific classes of mental disorder increased there was no separation of those with psychological disorders from the sick role. All sufferers from mental disorder became firmly locked into the role of patient no matter what form it took, in spite of increasingly specific and detailed diagnostic categories which began to make judgements about the causes of the problem. (With the development of community based care and a blurring

of the domains of medical and social care, this change may be beginning to happen now.

The MHA 1983 is still mainly about custody and but with the new approaches to treatment it also gives authority for treatment without, or even against, the patient's wishes. Implicitly, this could be seen as the greater good of society taking precedence over the needs of the individual - (if this was to be applied to other treatment, in he current zeal for preventative medicine, perhaps we may see parents being fined for not having their children immunised).

In summary it can be said that whilst attitudes towards mental disorder have changed, and treatment has become more successful, there has been little change in principle in the concept of custody between the 1890-1991 Acts and the MHA 1983. The conditions and safeguards are probably better but the concept of custody and involuntary detention remains an integral part of mental health care. This only applies directly to a relatively small number of patients but is always a possibility for many of the informal patients and remains a dominant influence on how mental disorders are perceived both in the NHS and in society generally.

Comparison with America.

The law on mental health and the detained patients in America is not as clearly defined or as uniformly applied as in Britain (Herr et al., 1983). There are federal laws, state laws (which have a high level of variation between states) as well as a great deal of change going on in both the law and its interpretation. It can be argued that the Mental Health Act in Britain deals only with the needs of the person and does not seek to determine criminal culpability; this is done by a different and separate process. In contrast, the notions of mental disorder, "dangerousness" and responsibility for criminal actions appear to be intertwined in American mental health law.

There is also the issue of demanding and receiving the rights which patients have under the law - the equivalent of Commissioners and Tribunals does not seem to

exist at a federal level and exacting patient rights from the system is a matter of going through the legal system. This takes place against the mosaic of public and private health care funding and provision in the US which is very different to that found in the UK.

The existence of alternatives to hospitalisation is problematical in spite of the patients' legal right to the least restrictive mode of care. When community based care was originally set up with Federal "pump-priming" funding, to be followed up by States finding the funds to maintain the system, the results varied from disaster through to ideal depending on the support the scheme received in state legislatures. In some places it was so apparent that many mental health problems had their roots in deprivation and discrimination, leading to poor life chances for a community, that the profession of psychiatry and psychology developed new sub disciplines which incorporated the role of political activism. In some places this had an adverse effect on the allocation of state resources to projects when Federal funding ran out.

Neither of the authors (Herr et al., 1983, Moore, 1984) give a full account of the process of civil committal referring to it largely in passing before going on to discuss at great length the ways in which patients rights have often been ignored or even flouted before the existence of an advocacy movement and test cases undertaken in the courts. Therefore it is proposed that any comparison of the US and UK systems should concentrate on the issues which are under active debate assuming these to represent significant features of way the respective systems operate.

Several major strands are immediately apparent in the American arena; the relatively high involvement of mental disorder with criminality and its defence in court, the use of committal to a mental hospital as a form of custody, the perceived neglect of patients in many hospitals and the difficulty of finding a mechanism by which to appeal against detention, poor treatment and the general indifference of the system. The lack of viable alternatives to hospitalisation is a major factor, in spite of case law which directs that the principle of "least restrictive alternative" (LRA) must always be followed when contemplating the

restriction of a person's rights because of mental disorder. A further important strand is differences in the legal and psychiatric models of the mind and its functioning which are used in the debate particularly when this is in a court action.

The popular view of the American culture, fostered by film and fiction, makes it appear that it is highly litigious, always ready to go to court to seek redress for wrongs or to gain some advantage over another person. The academic literature on mental health legislation does nothing to contradict this view. The issue of competency to act when mentally ill, the need for enforced detention and the ability to give consent to treatment are associated with the wider issues of competency in guardianship, business and family affairs. The grounds on which a person can be committed to a mental hospital are similar to those given by the MHA 1983; being a danger to oneself, a danger to others and to be in need of treatment. However, in US law there is a broader concept of the danger this person presents to society as a whole if they are not confined. Must time has been spent in court by lawyers, acting as advocates for the mentally disordered, arguing that mental disorder *per se* does not automatically constitute incompetence to act in one's family affairs or to accept or decline treatment. In the UK this seems to be less of any issue perhaps because of the detail in the MHA and the recourse of the patient to review and appeal procedures. Given the use, in the US, of psychosurgery and other fairly drastic procedures in dealing with psychosis, in the recent past, it may be more a more relevant debate there.

There is also the use of mental disorder as a plea in criminal cases to gain mitigation of sentence on the grounds of diminished responsibility. Moore (1984) spends a lot of time discussing this; the extent of the debate suggests that it is a frequent occurrence. If this is the case, then the patient structure in US mental hospitals could well contain a different population to those in the UK where ordinary mental hospitals will take people on remand or serving a sentence when they have a mental illness but are not judged to be in a high risk category. People can be sent to a mental hospital for treatment as an alternative to a court imposed sentence but would not be excessively violent or dangerous people. People, such as Myra Hindley, who are judged to have acted from totally

disordered motives, the so-called "criminally-insane", are normally housed in special hospitals until it is judged safe to transfer them to conventional custody.

Much of the advocacy, undertaken from the early 1970s onwards has not been directed towards challenging the detention of individuals but has concentrated on improving conditions inside mental hospitals and the development of alternative schemes for treatment in the community. Herr (1983) notes that up to 1960 the means of challenging detention was available in principle but not in practice - lawyers shunned such clients and the obstacles to non-lawyers were too great to contemplate. However, the civil rights movements of the 1960s and the growth of public legal services in the 1970s led to challenges to the system. This was coupled with changes in legislation and in precedent case law which accelerated the run-down of many big state hospitals - not always with happy results.

In the case of *Wyatt v. Stickney* the state of Alabama was prosecuted for not providing adequate care and treatment for 5,000 patients in the Bryce Hospital. Following a cut in the budget, a suit was brought by staff and soon-to-be-discharged patients that the conditions were such that adequate treatment was not possible given the resources available prior to the budget cut let alone after it. Those bringing the case at first were joined by the American Psychiatric Society and the American Orthopsychiatric Society, acting as amici curiae and other bodies joined in as the case progressed. The case lasted for some years with hearings being spaced to allow the State to remedy matters voluntarily. The Court eventually defined minimum constitutional standards of treatment which set a precedent for judgements in many subsequent cases. Prior to this case many states had statute law and codes which defined standards of care but it took this landmark legislation to ensure that they were properly applied.

However, one of the possible responses to this was to reduce the size of mental hospitals by discharging patients to an absolute minimum of community based facilities and thereby reduce the cost of mental health care (which has always been a factor in America given that the commercial health care insurers are chary of paying for treatment in long term psychical and mental conditions). This was also challenged in the courts in the case of *Brewster v. Dukakis* were the court

ruled that if patients were to be discharged to the community for treatment then appropriate facilities must be created and funded. This was a benchmark decision for the provision of community care all over America.

The greatest difference between the US and UK, seen in the literature, is the way that change is initiated. In Britain, it seems that public opinion, expert opinion and pressure groups generally provoke a Government inquiry in the shape of a Commission and that subsequent legislation is made on the recommendation of that Commission although it is not necessarily binding. An example of this is the Percy Commission which led to the 1959 MHA although it was pressure from expert opinion which then led to the 1983 Act. A similar example is the NHS Review and Social Services Review which followed from the Griffiths Report in 1987. In contrast, the US system seems to respond to case law generated in the courts, in this case begun by concerned workers and taken up by powerful professional interest groups with government agencies also being involved. The cases quoted are only two examples of many but serve to illustrate the process. The US also has many more bodies involved in all aspects of public administration and finance is a more naked and contentious issue because of the tension between the public and private sectors as well as between Federal and state agencies.

The significance of the Act as an influence on the definition of mental disorder and as an influence on mental health services generally.

The material discussed above offers a wealth of opportunity for analysis and comment with the problem of where to start because many of the issues are interdependent. A reasonable starting point is to discuss the merits and demerits of the MHA 1983 and then consider it in comparison with older laws and with American law. It may seem strange make a comparison with a system which is on the far side of the Atlantic and not with other nearer countries in Europe but much of the criticism levelled at mental health care in the UK is predicated on work done in America with whom we share a common language and, by

assumption, a similar culture. In contrast, there are many different cultures in Europe with whom we do not have common ground in our history and contacts.

The MHA 1983.

Looking at the MHA 1983 in isolation shows a common sense definition of the reasons for which a person can be detained, a wealth of precisely defined types of detention governed by the purposes for which they are imposed and apparently a wide variety of opportunities for the detained person to challenge the continued loss of freedom. There are safeguards for treating people on remand or convicted of an offence to ensure that they are not just locked up and left indefinitely in hospital. There are several bodies charged with ensuring that the Act is properly applied and with acting as patient advocates as well as other bodies who are concerned with safeguarding the level of care provided: the MHA Commissioners, the Review Tribunals, the Lord Chancellor's Visitors, the Court of Protection and the Hospital Advisory Service There are public reports to Parliament and ad hoc public enquiries when malpractice is uncovered.

If all is apparently so thoroughly and carefully enacted, and legislated for, in mental health provision, the question is then - why should the issues currently be debated actively in the academic, public and political arena? What is the problem?

There are several elements to be extracted from this picture and one of the most important has been discussed previously - the debate on the definition of mental disorder. The whole edifice of the MHA and associated agencies is based on this. Essentially, mental disorder requiring detention is judged by social means - the behaviour of the person concerned. (Prior, 1997) Taking the distinction between signs and symptoms, (where symptom is the patient's experience of the effects of their problem and sign is an independent scientific test of the functioning of the organism) then the MHA can only define mental disorder only on symptoms. In turn, the definition of a symptom of mental disorder is socially defined as behaviour leading to the judgement that the person is a danger to themselves, to others or is in need of care because or their incapacity to

successfully look after themselves. Each one of these categories can only be judged relatively by the prevailing norms of acceptable conduct.

Logically, any change in society's definition of "danger to others", for example, could lead to a change in the grounds for detaining a person. It would not happen immediately because there is case law and precedent in law and accepted practice in medicine but with pressure from interest groups a change would eventually occur. It can be seen that, at the moment there is pressure from Government to accept potentially dangerous people back into the community, with safeguards such as the "at risk" register, as part of the NHS reforms. There is also a counter pressure from society to reverse this. Speculatively, it could be suggested that, in the long term, changes in social attitudes are more likely to move to greater restriction rather than greater acceptance. However, a parallel example is the 'normalisation' of care for people with learning difficulties and the transition from large hospitals to care in the community with pressure to accept this group into wider society. This caused outcry at first but seems to have been accepted now.

This point is doubly significant because the MHA is effectively concerned with custody. Whatever the provisions it makes for assessment, immediate or long term treatment, and the safeguards which are built in to ensure that there are properly provided, its main purpose is to define the conditions under which a person can be deprived of some, many or all of their freedoms to act in society.

A second point is that the MHA is only concerned with patients who need to be in custody for care and treatment; at the time of writing this was approximately 14% (2002 - MHA records). However, this is an underestimate of the number of people to whom the Act could apply as there is a substantial number of informal patients, who have voluntarily entered hospital for treatment, would be detained if they attempted to discharge themselves. It can be argued that in defining the standards and conditions for detained patients there will be a corresponding effect on the care of informal patients. If nothing else, there is always the spectre of detention hanging over patients if they chose not to conform to the prescribed regime of care.

Another element which is of great importance is that, by implication, the MHA imposes the sick role on people with socially defined problems. Leaving aside the vexed question of biological versus social factors in psychosis, there are few grounds on which the label can be justified. The MHA is not solely responsible for this although it must contribute to it. In the 19th Century and early 20th Century the law provided for care of the mentally disordered in three ways: private houses, asylums and hospitals. There was to be medical care in all three but apparently for the physical health of the inmate. It should also be noted that asylums, where mentally disordered people where kept at public expense if they did not have the resources to pay for their care, were under local authority control and this only changed in 1948 when the asylums were transferred to the newly founded National Health Service. The discipline of psychiatry also evolved during this period under the influence of Breuer, Charcot and Freud (Fadiman & Frager, 1976) as did psychology and sociology - it is be interesting to speculate what the care of mentally disordered people would be like if Durkheim had extended his work on suicide and some of the earlier worker in other social sciences had been involved in mental problems - it may have become a branch of social work with medical cover much as the current reforms are suggesting for those with long term problems. As it was, the care of mental disorder became a branch of medicine with the unique distinction of having legal powers to enforce its presence in people's lives. It is suggested that this reinforced the social perception of mental disorder as a "sick role".

The movement to care in the community is intended to redress this mismatch and many staff eschew the label "patient" in favour of "client", or "resident" for those in continuing care. The intended effect is to draw a parallel with people who need the services of social work rather than of medicine. This is somewhat paradoxical in that the care is still predominantly provided by nurses and doctors. (Psychology is slightly different as it overlaps with the health services but has a substantial presence in non-medical fields.) The law defines mental disorder as deviance and the label is likely to be perpetuated in spite of efforts to make changes in the world view of our society.

Comparison between the MHA 1983 and American Mental Health Law.

The critique of mental health care in hospitals in the UK has to a large extent been referred to work done in America, particularly that of Goffman in Asylum and Stigma (Goffman, 1986 & 1986a). There are several caveats which need to be made about this use of the work: it was done in the 1960s on a small group of people (Scull in Bean 1985), the situation in America has moved on from that studied by Goffman and the concern and operation of American law is different to that in the UK (Herr, 1983, Moore, 1984) which will produce a different mix of patients and problems in hospital.

The pathway for the critique is, roughly, a set of indifferent American laws which hospitalised people with mental disorder, sociological investigation of the hospital and the development of the concept of "total institutions". the use of this concept when looking at UK mental hospitals and then, coupled with the ideological drive to community based care, the perception of all long term hospital care as undesirable even though the hospital population and their treatment was different to that in the US.

Reference to the section above on US law suggests that in the 1950/60s there was a greater emphasis on dangerousness coupled with inadequate treatment in hospital and few, if any, alternatives for those who were reliant on the public health system. This has now changed and there is a movement towards community based care and the least disruption to a persons daily life and functioning whilst having treatment - enshrined in American case law as the Least Restrictive Alternative principle. (But, the literature suggests that the progress towards this goal is more patchy in the US as it relies on initiatives at state as much as at federal level.) Perhaps the most used and well quoted idea to come from work in the US was the concept of mental health care hospitals as being "total institutions" with many features in common with places like jails and at worst the concentration camp. This naive and simplistic metaphor cannot be sustained today except in the most extreme case where no progress at all has been made.

Against this background the MHA 1983 appears to be humane and to supply the means to avoid abuse and unjust detention. It would be easy to develop an apologia, using the American material, to show that the MHA is minimising the use of detention and only permitting it where absolutely necessary to the welfare of the individual. This also would be a somewhat uncritical and naive position: it avoids the question of how we can justify having a law which sanctions restrictions on liberty, and the imposition of the sick role on a person, on the basis of behaviour for which there is no detectable physiological dysfunction. It is around this point that most of the issues hang.

Overview.

The growth of community based care will perhaps create some change in the perception of mental disorder in our society because if nothing else the MHA only applies to inpatients and there are more and more people with psychotic problems living in the community without restraint. This could have a negative effect with hospitals being reduced to caring for only those whose symptoms are intractable and whose behaviour is perceived as creating some sort of problem. If the proportion of detained patients rises, the risk of creating a total institution, as Goffman's describes, also rises.

Observations made so far suggest that those working in the community are aware of some of these issues and are trying to create a new environment. The observations also indicate that these same practitioners are creating a culture with new and different types of control; by definition a person would not be undertaking day care if they could run their own lives without help.

MENTAL HEALTH UNIT
SOUTH WEST DURHAM

COMMUNITY MENTAL HEALTH CENTRES

SERVICE SUMMARY

- better care locally.

Multi-professional Community Mental Health Teams are based in local centers and give people quick easy access to help from psychiatrists, nurses, social workers, psychologists, occupational therapists and other specialist professions allied to medicine. They are the "front line" services we provide. In South West Durham, we aim to have Community Mental Health Teams in local Centres; we will have one other Community Mental Health Team specialising in the Elderly Mentally Ill.

Community Mental Health Team's currently operate from:-

- Barnfield Centre, Spennymoor
- Phoenix Centre. Newton Aycliffe
- Dawson House, Crook

A further two teams are to be established in Sedgefield and Bishop Auckland.

XXXXXX CENTRE COMMUNITY MENTAL HEALTH CENTRE

MEMBERS OF THE COMMUNITY MENTAL HEALTH TEAM

FULL TIME MEMBERS:

Acting Co-ordinator (R.M.N. R.G.N.)
Administrator (Higher Clerical Officer)
Social Worker Level 2 (Joint Funded) Social Worker Level 2
Occupational Therapist (Head III)
Community Psychiatric Nurses:

- Grade G x 2
- Grade G x 1 (seconded into Team)
- Grade E x 1
- Grade B x 1 (Support Worker)

P ART TIME MEMBERS

Consultant Psychiatrist
Clinical Psychologist
Behavioural Nurse Therapist
Associate Specialist in Psychiatry (Grade 3)
Registrar (Rotational/Intermittent)
Occupational Therapist

ADDITIONAL SESSIONAL INPUT

Physiotherapist
Dietician
Pharmacist

SERVICE AIMS

A comprehensive, locally based Mental Health Service meeting local needs for adult and elderly mental health care.

- An accessible service :
- Direct open referral drop-in facilities mobile team minimising delay and system formality.
- A co-ordinated Mental Health Service of multi-disciplinary professionals offering a direct service to individual users, groups and carers.
- A choice of service for clients and referrers, offering a wide range of assessments and therapies.
- To maximise involvement of the 'Community' and interpersonal networks in providing support for people with Mental Health Problems and promote understanding in the community through education.
- Monitoring of service provision and user need to maximise responsiveness to changes in need and to ensure high Quality in Service delivery.
- To act as an information resource to the local community.
- To reduce to a minimum the need for N.H.S. hospital provision for people with Mental Health Problems.

SERVICES PROVIDED

Include :-

- Psychological assessment
- Social assessment
- Psychiatric assessment - nursing and medical
- Functional assessment
- Practical teaching
- Public education and health promotion
- Range of therapeutic approach, depending upon individual professional counselling- individual, group e.g. bereavement
- Marital problems obsession/compulsions

Behavioural approaches - Advice and support

Group work is available for

- Anxiety Management
- Anxiety Management Support Group
- Anger Control
- Carer Support
- Social Skills
- Leisure Skills
- Relaxation Therapy
- Post-natal Women
- User Group
- *Young Women's Social Support Group Assertiveness Training.

These are run as needs dictate, except * - ongoing.

October 1992

: Blank Interview Schedule.

Interview

Date:

Respondent Code:

Tape code label:

Preliminary to interview:

Thank respondent for taking part.
State or reiterate that whilst this project is sponsored and supported by the Board it is not part of my normal work and all material will remain confidential - all tapes and transcripts will be coded so that the identity of the respondent is not apparent.

Topics/issues to be raised in semi-structured interviews:

Interview Topics:

- Training
- Experience in hospital
- Experience in community
- Move to community - how and why
- what does the word community mean
- Comparison of hospital and community nursing - styles and content
- GPs versus consultants - relationships, expectations, roles
- Patient expectations - in hospital and in the community
- GP referrals - case mix
- Origin of people's problems
- Can all problems be treated in community - if not, why not

- Do CPNs do a good job - how do they know
- Specification for the "ideal" CPN
- The future - where are CPNs going - where SHOULD they be going
- Pressure of the job - supervision formal and informal/ team support
- Anything to add that I've missed

Key words/topics to be followed up whenever they occur:

- criticism/complaints about anything,
- mention of holistic/humanistic/community care (get definitions and understanding of this)
- relationships with medicine generally /GPs/consultants
- differences between CPNs and other areas/types of nursing
- issues of empowerment/helplessness/social issues
- issues of the origins of patients' problems
- use of jargon/technical terms: explore what they mean and why used.

(Revision 3 intsched3.doc)

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